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In the Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 and EAST JEFFERSON HOSPITAL BOARD, PETITIONERS

v.

EDWIN G. HYDE, RESPONDENT

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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QUESTION PRESENTED

Whether an arrangement by which a hospital secures the full-time, exclusive services of anesthesiologists to attend its patients is unlawful per se under the Sherman Act because it "ties" the patient's use of the hospital's operating room to the use of the hospital's anesthesiologists.

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OPINIONS BELOW

The opinion of the court of appeals (App. A, *infra*, 1a-19a) is reported at 686 F.2d 286. The opinion of the district court (App. B, *infra*, 20a-47a) is reported at 513 F. Supp. 532.

JURISDICTION

The judgment of the court of appeals (App. C, *infra*, 48a) was entered on September 20, 1982. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTE INVOLVED

Section 1 of the Sherman Act, 15 U.S.C. § 1 (1976), provides in relevant part: "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several states, or with foreign nations, is declared to be illegal."

STATEMENT

1. East Jefferson General Hospital is a large public hospital in the New Orleans metropolitan area.[1] At its opening in 1970 the Hospital concluded that anesthesia services would be best provided if the Hospital had the full-time services of one or more anesthesiologists. It accordingly invited anesthesiologists to make proposals for a contract to provide these services.

After some negotiations, which included discussions with respondent (who had moved from practice in Florida to practice at a hospital in metropolitan New Orleans), the Hospital entered into a contract with Roux & Associates ("Roux"), a professional medical corporation. The contract was "exclusive": Roux promised that its anesthesiologists would not work elsewhere, and the Hospital agreed not to engage other anesthesiologists during its term. The term of the contract was one year, renewable for additional yearly periods unless either the Hospital or Roux should give 90 days' notice.

The Hospital was well satisfied with the services of the Roux anesthesiologists, and it allowed the contract to be renewed automatically until 1975, when it again

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[1] The Hospital is governed by petitioner Board of Directors, twelve people selected by petitioner Jefferson Parish Hospital District No. 2. The District is a political subdivision of the State of Louisiana. The Hospital was constructed with public funds in 1969. Day to day administrative decisions for the Hospital are made by an executive director selected by the governing body of the District. For convenience we refer to the two petitioners, the Hospital, and its executive director as "the Hospital."

The Hospital generally operates as a business, and petitioners have not argued that their decisions are protected by the state action doctrine of *Parker* v. *Brown*, 317 U.S. 341 (1943). See *Community Communications Co.* v. *City of Boulder*, 455 U.S. 40 (1982).

reviewed the arrangement. It considered other options and proposals and once more selected Roux to provide services.

The contract signed in 1976 ran for five years. Like the 1971 contract, it called for Roux to supply all of the necessary anesthesiology services at the Hospital. Although it was not labeled "exclusive," it provided that Roux would supply all anesthesiology services required for the care of the Hospital's patients (App. A, *infra*, 2a n.1; App. B at 23a). Like the 1971 contract, this one also called for Roux to supervise the anesthesia department and the nurse anesthetists who performed many of the routine procedures, and schedule the procedures. It gave Roux the ability to hire and fire the nurse anesthetists who would be employed by the Hospital. It gave the Hospital complete discretion to establish the charges to patients for anesthesia, requiring only consultation with Roux. The fees of Roux were set at 46% of the total billings of the anesthesiology department; the remainder of the billings pay the nurses' salaries and compensate the Hospital for space, equipment, and supplies. Roux thus was compensated whether its anesthesiologists performed the services or supervised their performance by nurse anesthetists.

Respondent applied in 1977 for a position on the Hospital's medical staff. The Credentials Committee of the staff approved his credentials, but the Board of Directors declined to admit respondent to the staff. It based this decision on the ground that the contract with Roux called for its anesthesiologists to supply all of the needed services (App. B, *infra*, 25a-26a). Respondent then filed this suit under the Sherman Act, contending that the contract with Roux was unlawful because it "tied" patients' use of the Hospital's operating rooms to

their use of Roux's services.[2] Respondent sought an injunction admitting him to practice in the Hospital, but he did not seek damages.

2. The district court entered judgment for petitioners after a bench trial (App. B, *infra*). It assumed without discussion that the contract establishes a tie-in and applied the Rule of Reason to the contract because, it concluded, the Hospital has no significant market power.[3] It then held the contract lawful because it produces significant competitive benefits and no countervailing anticompetitive effects.

With respect to market power the district court made a factual finding that the Hospital does not have "any advantages over any other hospitals in the area" (App. B, *infra*, 34a) and is in no "position to charge patients higher prices or to impose burdensome terms which could not be extracted in a completely competitive market" (*ibid.*). It based this latter conclusion on findings that the Hospital competes for patients in the New Orleans metropolitan area (*id.* at 33a). The court observed that patients choose hospitals throughout the

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[2] Respondent also argued that the denial of his application for staff privileges violated the Fourteenth Amendment's due process clause (both substantively and procedurally) and two Louisiana statutes. The district court rejected all of these contentions (App. B, *infra*, 42a-47a). The court of appeals did not reach them in light of its antitrust holding (App. A, *infra*, 5a n.3), and they are therefore not before this Court.

[3] The district court also concluded that the Rule of Reason should be applied because of the special circumstances of the medical profession (App. B, *infra*, 39a-41a). The court of appeals rejected this conclusion (App. A, *infra*, 14a-18a) in light of *Arizona v. Maricopa County Medical Society*, 102 S. Ct. 2466 (1982), and we do not present this aspect of the Fifth Circuit's decision for review by this Court.

area and that only 30% of those who live in East Jefferson Parish obtain hospital care at the Hospital (*id.* at 33a, 38a-39a). The court acknowledged that 70% of the Hospital's patients come from its neighborhood (*id.* at 39a) but reasoned that this does not show market power.

With respect to the benefits of the contract, the district court concluded that the arrangement ensured 24-hour service, "aids in the control and standardization of procedures and the efficient and less costly operation of the department[,] lends flexibility to the scheduling of operations [,] . . . permits the physicians, nurses and other technicians in the department to develop a work routine and a proficiency with the equipment they use in patient treatment; and it increases the Board's ability to monitor the medical standards exercised because there are fewer individuals involved" (App. B, *infra*, 32a-33a). Moreover, the court explained, the contract did not suppress competition but rather created more competition: "A closed department may enhance competition among the hospitals in the market by increasing the quality of medical care available. It may also serve to benefit competition among anesthesiology groups if the terms of the exclusive contracts are not for unreasonable periods of time. Such a system would serve to encourage anesthesiologists to improve the quality of their services in order to obtain these contracts with hospitals" (*id.* at 34a). It therefore entered judgment for petitioners.

3. The court of appeals reversed. It first held that the contract is a tie-in because patients in the "hospital's operating room (the tying product) are also compelled to purchase the hospital's chosen anesthesia service (the tied product). It is also clear that we are dealing with two distinct services which a buyer should be able to obtain separately" (App. A, *infra*, 5a-6a).

It next held that the Hospital possesses market power as a matter of law because of "market imperfections in the health care industry" (App. A, *infra*, 9a). Although the Fifth Circuit did not find any of the district court's conclusions clearly erroneous, it pointed to the prevalence of third-party payments that reduce the incentives of patients to shop for low prices and the lack of complete information about the services they are buying; it also asserted that "patients tend to choose hospitals by location rather than price or quality" (*ibid.*). As a result, the court of appeals held, the geographic market is smaller than metropolitan New Orleans, the Hospital's market share is larger than the district court thought, and the Hospital thus has "sufficient market power in the tying product to coerce purchase of the tied product" (*id.* at 10a).

The court of appeals did not hold that the contract elevated prices of either anesthesia services or the package of operating rooms and anesthesia (App. A, *infra*, 11a-12a). The court concluded, however, that constant or declining prices coupled with the lower costs of service made possible by the contract just led to profits for the Hospital, which demonstrated the vice of the contract (*ibid.*).

Finally, the court of appeals turned to the consequences of the contract. It held that the benefits found by the district court could not be used to sustain the contract because the Hospital had not established that a closed anesthesia department is the least restrictive alternative for the creation of these benefits (App. A, *infra*, 13a). Moreover, the court expressed doubts about the existence of these benefits. One finding, concerning the contract's utility in guaranteeing 24-hour service, was held clearly erroneous (*id.* at 3a-4a & n.2, 11a n.7); others, such as the findings concerning competition

among anesthesiologists for the contract, were put to one side (*id.* at 12a n.9); still others, such as the findings concerning the supervision by Roux of the nurse anesthetists and the Hospital's supervision of Roux, were simply not mentioned.[4]

REASONS FOR GRANTING THE PETITION

1. The holding of the court of appeals sweeps aside as unlawful per se the "common practice in the health care industry for hospitals to enter into exclusive contracts with physicians" (App. B, *infra*, 32a). See also *Dos Santos* v. *Columbus-Cuneo-Cabrini Medical Center*, 684 F. 2d 1346, 1351 (7th Cir. 1982) (similar arrangements are "widespread" and have "been adopted by most hospitals in the Chicago area").

Hospitals routinely put together services, including space, equipment, drugs, blood, nurses, food, and some medical specialties such as anesthesiology, radiology, and pathology, that are delivered to patients as a package of medical care. These medical specialties and other inputs have in common the fact that they are needed for many hospital procedures, so that a full-time hospital-based staff is advantageous; at the same time, patients rarely know the identity of these specialists, so that a hospital's provision of these services by its own staff does not affect the degree of choice the patient possesses over his own care.

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[4] The court of appeals stated, for example, that the contract "reduces the incentive for improving or initiating techniques or procedures. Quality is lowered" (App. A, *infra*, 12a). The court did not mention, let alone hold clearly erroneous, the district court's contrary finding of fact. (It did hold erroneous, *id.* at 11a n.7, any finding that "strictly quality considerations" account for the arrangement.)

Until now every federal court that has considered an antitrust attack on such assembly of medical services had upheld the hospital. E.g., *Dos Santos, supra* (adopting the reasoning of the *district* court in this case and rejecting an argument that exclusive medical contracts amount to a boycott or other per se violation); *Harron* v. *United Hospital Center, Inc.*, 522 F.2d 1133 (4th Cir. 1975), cert. denied, 424 U.S. 916 (1976) (an antitrust challenge to an exclusive medical contract is so "frivolous" that the suit must be dismissed for want of federal jurisdiction); *Capili* v. *Shott*, 620 F.2d 438 (4th Cir. 1980) (exclusive arrangement is reasonable and challenge also fails to show effect on interstate commerce); *Robinson* v. *Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981), aff'd mem., 688 F.2d 824 (3d Cir. 1982), cert. denied, Nov. 1, 1982, No. 82-415 (rejecting after trial a large number of different antitrust claims). Every state court that has encountered similar claims under state antitrust law also has sustained the hospitals' practices.[5]

The Fifth Circuit's decision thus creates a conflict. Practices that are unlawful per se in Louisiana, Texas and Mississippi are lawful and prevalent everywhere else.

The court's reasoning, moreover, is difficult to cabin. The court has depicted the Hospital as a sort of bazaar in which physicians hawk their wares to assorted

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[5] *Rumple* v. *Bloomington Hospital*, 422 N.E.2d 1309 (Ind. App. 1981); *Centeno* v. *Roseville Community Hospital*, 167 Cal. Rptr. 183 (Cal. App. 1979); *Dattilo* v. *Tucson General Hospital*, 23 Ariz. App. 392, 533 P.2d 700 (1975); *Letsch* v. *Northern San Diego County Hospital District*, 55 Cal. Rptr. 118 (Cal. App. 1966); *Blank* v. *Palo Alto-Stanford Hospital Center*, 234 Cal. App. 2d 377, 44 Cal. Rptr. 572 (1965).

bystanders. Because anesthesia *can* be sold separately from surgery and blood in such a marketplace, it *must* be sold separately.

On this reasoning, however, every product is a tie-in to the extent it contains potentially-severable elements. Every hospital supplies nurses and food rather than allowing patients to bring (or designate) their own favorites.[6] Most hospitals supply radiology, pathology, and anesthesiology; many hospitals supply cardiology and other specialties too.

Under the court's approach such "tie-ins" are unlawful per se because every hospital has market power as a matter of law. The court inferred market power from "imperfections" that are generic to the health care industry and from the fact that many patients use hospitals located near them. Every time a hospital furnishes a "tied" package, then, it commits a crime.

Any group practice of medicine also is unlawful per se, because each involves a package sale and the same generic market power. The Group Health Association in the District is a colossal web of antitrust offenses under the Fifth Circuit's holding because one cannot hire GHA's podiatrist without taking its dermatologist.

There is, moreover, no way to stop the analysis at the border of medicine. General Motors *could* offer customers a choice of Firestone and Goodrich tires for its cars. Thus if GM puts its tire requirements out for bids, and one year buys only Firestone tires because Firestone made the low bid, it has committed a per se violation of the antitrust laws.

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[6] Nothing in this case turns on the fact that Roux is a separate corporation. The Fifth Circuit's analysis would be equally applicable if the Roux anesthesiologists were employees of the hospital.

2. The decision has substantial importance even if the holding is confined to hospitals. Available data suggest that at least half of all hospitals have exclusive arrangements in radiology, pathology, anesthesiology, or all three; all hospitals hire their nurses and several other medical inputs.

A survey conducted by the AMA[7] found that in 1981 some 78,600 physicians, or 26% of all nonfederal patient-care physicians excluding residents, had contractual arrangements with hospitals. Some of these contracts doubtless are not exclusive, but other physicians must have de facto exclusive arrangements not entailing contracts, so the data are a guide to the scope of the challenged arrangements. Some 78% of the 8,500 pathologists, 58% of the 15,800 radiologists, 27% of the 13,100 anesthesiologists, and 11% of the surgeons reported such arrangements. The average annual net income derived from the arrangements is $114,100 for each of these pathologists (or 96% of pathologists' total annual income), $108,900 for radiologists (or 80%), and $84,400 for anesthesiologists (or 87%). The annual volume of commerce affected by exclusive medical services contracts thus is approximately $2.05 billion for the three hospital-based specialties alone; it is much greater if the contractual income of other medical professionals is included.

The figures look much the same if viewed from the perspective of hospitals. In 1972-74 roughly 20% of hospitals had salaried pathologists and another 40% compensated their pathologists by a percentage of

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[7] American Medical Association, Center for Health Policy Research, *SMS Report* (Feb. 1982).

departmental income (a close proxy for exclusive contracts).[8] For radiologists these figures are 6% employed and 62% so compensated in 1972; 10% employed and 55% so compensated in 1974. (The study did not obtain data for anesthesiologists.) Exclusive contracts seem to predominate in American hospitals. By any measure of importance, then, the court of appeals' judgment requires review by this Court.

3. The court of appeals' decision is as misguided as it is important. The antitrust objection to tie-ins is based on their use of leverage to transfer monopoly power from one product to another. See *United States Steel Corp.* v. *Fortner Enterprises, Inc.*, 429 U.S. 610, 617 (1977) (*"Fortner II"*). Leverage is impossible unless there is both monopoly power in the tying good and some mechanism to transfer that power to the tied good. The theory of tie-ins is that the price of the tied good will rise as it partakes of the tying good's monopoly power. As the Court held in *Fortner II*, however, a package sale is not unlawful if the package price is competitive.

Yet respondent has not alleged, and the court of appeals did not find, that the anesthesiology arrangement caused an increase in the price of the operating room/anesthesia "package." Indeed, the court observed that the price of anesthesia had not risen (App. A, *infra*, 11a-12a), and it did not suggest that there was a corresponding rise in the price of operating room time.

This was attributable in substantial part to the allocation of duties between anesthesiologists and nurse anesthetists that the arrangement made possible.

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[8] Data from Paul J. Feldstein & Charles Roehrig, *An Analysis of Exclusive Contracts and Closed Staffing in Hospitals: The Effects on Competition*, a report to the FTC.

Because Roux is solely responsible for anesthesia in the Hospital, it will make an efficient allocation between these services. Thus four anesthesiologists can cover fourteen operating rooms in the Hospital. In an "open" department, by contrast, anesthesiologists will try to supply their own services even though a particular procedure could be performed more effectively, and at lower cost, by the highly-specialized nurse anesthetists who operate under the constant guidance of Roux in the Hospital's "closed" department. An "open" department would destroy both the incentives and the supervision that make these savings possible.

But whatever one makes of the argument that there are efficiencies in the joint supply of operating rooms and anesthesia, the fact remains that the "tie" is not a method of increasing the price received by the anesthesiologist. To the contrary, as the district court found, competition among anesthesiologists to obtain the positions will reduce the price of their services. In this case the Hospital obtained, by contract, complete freedom to set and reduce the fees charged by Roux. Bidding for the position reduces price, which may explain why the American Society of Anesthesiologists apeared as amicus to support respondent.

4. There are at least three mistakes in the Fifth Circuit's treatment of the arrangements. We address them in turn.

a. Tie-in doctrine is simply inapplicable where, as here, the arrangement *creates* the product the Hospital sells. A suit with buttons, a car with tires, an encyclopedia with 25 volumes rather than 1 or 15, all are single products. The fact that the seller could conduct its business so as to multiply the number of products is irrelevant. What makes a tie is the fact that two items, each

independently useful, are put together and the customer coerced to take both even though he needs but one. See, e.g., *Times-Picayune Publishing Co.* v. *United States*, 345 U.S. 594 (1953); *Hirsh* v. *Martindale-Hubbell, Inc.*, 674 F.2d 1343 (9th Cir. 1982), cert. denied, Nov. 1, 1982, No. 82-570; and *Principe* v. *McDonald's Corp.*, 631 F.2d 303 (4th Cir. 1980), cert. denied, 451 U.S. 970 (1981), among the many decisions that reject the Fifth Circuit's approach of defining a tie-in by looking for potentially-severable items in a larger bundle. These cases hold, instead, that there is no tie if the products are customarily sold together; surely there is none, they say, if the products are not sold in separate markets.

Under the standard adopted by these cases, the arrangement at issue here is not a tie-in. Operating rooms and anesthesia are not independently useful. The utility of one depends on the supply of the other. There is no market for operations without anesthesia. A patient contracts for "surgery" and depends on the hospital or the surgeon to secure space, blood, oxygen, nurses, anesthesia, and the other essential ingredients of medical care. The patient inevitably sees the transaction as a package deal.[9]

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[9] Respondents doubtless will reply that operating rooms and anesthesiology are separate products because they are priced separately on patients' bills. This cannot be the legal test of multiple products, though. A law firm prices partners' time, associates' time, and expenses separately, yet no one thinks of legal services as a tie-in. Hospitals price oxygen and blood separately, but no one would seriously argue that the joint provision of patients' rooms and oxygen is a tie-in. Hospitals' pricing practices are designed to fulfill requirements of those (insurers and governmental agencies) who pay most bills and to encourage patients who pay their own charges to conserve in their demands on the hospitals' services.

b. Even if the package sale to patients is a tie-in, it is not unlawful unless the tie was used to transfer market power from the tying good to the tied good. For this to occur there must be both power and transfer. Neither is present here.

As we have pointed out above, there is no finding that the tie elevated either the package price or the price of anesthesiology. Without such a finding, there is no market power. The Fifth Circuit's contrary holding conflicts with *Fortner II* and, e.g., *Kypta* v. *McDonald's Corp.*, 671 F.2d 1282 (11th Cir. 1982), cert. denied, Oct. 4, 1982, No. 82-6 (dismissing a case because plaintiff did not allege or prove an elevation in the price of the package). But see *Bell* v. *Cherokee Aviation Corp.*, 660 F.2d 1123 (6th Cir. 1981) (in accord with the Fifth Circuit, finding market power without proof of effect on price).

The fact that people who live near the Hospital prefer to use its services does not establish market power — at least not unless every corner grocery also has market power as a matter of law. A small grocery draws most of its customers from its neighborhood even if it is in the shadow of a large supermarket. The origin of its customers would prove nothing about market power. The same is true here. There is no proof that the Hospital could charge elevated prices because of this preference; the district court found as a fact that it could not (App. B, *infra*, 34a, 38a-39a). The preference of neighbors probably reflects the Hospital's good service and competitive prices rather than monopoly power.

As for the Fifth Circuit's belief that the provision of medical care is noncompetitive as a whole, there are two flaws. First, there is no evidence to this effect in the record, and it cannot be the subject of judicial notice.

This Court's decision in *Arizona* v. *Maricopa County Medical Society*, 102 S. Ct. 2466 (1982), is based on a belief that the provision of medical care is ordinarily competitive. The court of appeals' "evidence" of imperfect competition concerned the lack of complete information, the prevalence of insurance, and other features present in most markets to a greater or lesser degree (App. A, *infra*, 9a). One cannot take the presence of such features as establishing market power without proof; indeed, one probably cannot use them as indicia of market power at all without holding that all markets are noncompetitive.

Second, such a finding would have nothing to do with the tie alleged in this case. If the Hospital has market power vis a vis patients, it can exploit this power whether or not it has a closed anesthesiology department. It could tack a surcharge onto the patient's bill for each anesthesia procedure. If instead of doing this the Hospital allows anesthesiologists to increase their fees, it loses the income it could obtain. A higher cost of anesthesiology would hurt the Hospital as well as the patients. Thus the Hospital's incentives in securing anesthesia are congruent with patients'. Both gain from competition among anesthesiologists.

Because the Hospital's market position vis a vis its patients is unaffected by the way in which it secures or furnishes anesthesia, the right market perspective is the

national market in which the Hospital secures anesthesiology services from professionals, as the Seventh Circuit held in *Dos Santos, supra*, 684 F.2d at 1354,[10] and as *Tampa Electric Co.* v. *Nashville Coal Co.*, 356 U.S. 320 (1961), indicates, rather than the market in which the Hospital serves patients. See also *RCM Supply Co.* v. *Hunter-Douglas, Inc.*, 686 F.2d 1074, 1076-77 (4th Cir. 1982). Surely respondent's "foreclosure" from obtaining one of the four positions at the Hospital did not affect competition in any discernible fashion.

c. Finally, the court of appeals erred in consigning the Hospital's proof of efficiencies, and the district court's findings concerning the benefits of the arrangements, to the "least restrictive alternative" dustbin. Nothing ever passes the least restrictive alternative test, since one can always *imagine* some less restrictive rule that, in a hypothetical world, produces benefits without corresponding costs. "A judge would be unimaginative indeed if he could not come up with something a little less 'drastic' or a little less 'restrictive' in almost any situation" (*Illinois Election Board* v. *Socialist Workers Party*, 440 U.S. 173, 188 (1979) (Blackmun, J., concurring)). The degree of economic integration is variable in any business. Some pen manufacturers make their own ink, while others buy ink from specialty firms. Some hospitals have "open" departments of anesthesiology, while most have "closed" departments.

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[10] "The patient . . . receives the services but does so without making any significant economic decision. It may thus be more appropriate for antitrust purposes to treat the *hospital* as the purchaser, in view of the hospital's responsibility for assuring the availability of anesthesia services for its patients . . . . If the hospital . . . is regarded as the purchaser, the relevant market could be defined as the area . . . in which the [hospital] (rather than the patient) can practicably turn for alternative provision of anesthesia services."

A "least restrictive alternative" approach stifles beneficial innovation in the delivery of professional services. One cannot show that any given arrangement is perfect or costless. Nonetheless, the benefits of the arrangement — including most particularly the supervision of the nurse anesthetists — lie at the heart of the case. They illustrate why the Hospital thought exclusive arrangements preferable to an open department. A court cannot sweep them aside as irrelevant (except to a defense that can never be made out) without missing the whole point of tie-in doctrine. Courts call some practices tie-ins because of a belief that putting odd products together in a package hardly ever serves a purpose besides restricting competition. They call other practices (such as selling cars with motors already in them and ball point pens with refills in them) not tie-ins because the gains produced by such prepackaging are apparent. The savings to be had from a practice are pertinent both to the characterization of the practice as a tie-in and to the question whether the practice, so characterized, must be held unlawful per se. Cf. *Continental T.V., Inc.* v. *GTE Sylvania Inc.*, 433 U.S. 36 (1977); *Broadcast Music, Inc.* v. *CBS, Inc.*, 441 U.S. 1 (1979).

The benefits in this case are the same as those of selling cars with motors. They are the benefits of economically-integrated production. As the Court pointed out in *Maricopa*, the antitrust laws are principally directed against naked cartels, not against economic integration. "If a clinic offered complete medical coverage for a flat fee, the cooperating doctors would have the type of partnership arrangement in which a price fixing agreement among the doctors would be perfectly proper." 102 S. Ct. at 2480. Such cooperative medical

coverage is exactly what the Hospital and Roux offer, exactly what the Fifth Circuit held to be illegal per se. That cannot be the law.

CONCLUSION

The writ of certiorari should issue.

Respectfully submitted.

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December 17, 1982

APPENDIX A

DR. EDWIN G. HYDE, PLAINTIFF-APPELLANT,

v.

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 AND EAST JEFFERSON HOSPITAL BOARD, DEFENDANTS-APPELLEES.

No. 81-3091.

UNITED STATES COURT OF APPEALS, FIFTH CIRCUIT.

Sept. 20, 1982.

Appeal from the United States District Court for the Eastern District of Louisiana.

Before GARZA, POLITZ, and WILLIAMS, Circuit Judges.

GARZA, Circuit Judge:

Doctor Edwin Hyde brought this action to challenge his exclusion from the medical staff of East Jefferson General Hospital in Metairie, Louisiana. He sought a declaratory judgment that the actions of the Hospital District and its Board of Directors violated Section 1 of the Sherman Act, 15 U.S.C. § 1; the Due Process clause of the Fourteenth Amendment; Sections 51:122 and 123 of the Louisiana antitrust law; and Section 46:1058 of the state enabling legislation under which the Hospital District was created. Hyde also prayed for the issuance of an injunction ordering defendants to appoint him to the hospital's medical staff. Following a trial on the merits, the court below dismissed the suit. In this appeal,

plaintiff concentrates his attack on the Sherman Act portion of the district court judgment. Today, we reverse the court's judgment, for reasons stated herein. 513 F.Supp. 532.

Doctor Hyde is a board certified anesthesiologist who practices in Jefferson Parish, Louisiana. In July, 1977, he submitted an application for admission to the East Jefferson Hospital medical staff. New staff members are ultimately selected by the East Jefferson Hospital Board. According to the language of La.R.S. 46:1058 concerning the selection of new medical staff, "[s]uch appointments shall be made upon the recommendations of the physicians who are authorized to practice within the hospital." Appellant's application was therefore initially sent to the medical staff, which functions as a separate entity from the hospital. First, the Credentials Committee reviewed Hyde's medical qualifications and submitted a favorable recommendation to the Medical Staff Executive Committee. That committee then reviewed the application and recommended to the Hospital Board that appellant's application be approved. In spite of favorable recommendations from both medical staff committees, the Board voted to deny staff privileges to Dr. Hyde.

This action was occasioned by the fact that the hospital had an exclusive contract with Roux and Associates, a professional medical corporation, to provide anesthesia services.[1] Under the terms of this contract, the anesthesiologist determines the fee for the services

[1] The first contract between the parties was executed in February, 1971, and explicitly granted to Roux the exclusive right to provide anesthesia services. This exclusive language was deleted when the parties entered into a second contract in January, 1976. However, the executive director of the hospital testified that another provision, retained in the 1976 contract, had the same effect

he provides based upon the complexity and length of the operation performed. Patients are billed jointly for the anesthesia services provided by the doctor and by the hospital. The hospital deducts eight percent for bad debts, charity and other write-offs from the gross receipts of the department and then remits fifty percent of the remaining sum to Roux and Associates.

The provision of anesthesia services in each of East Jefferson Hospital's thirteen operating rooms is, in large part, undertaken by nurse anesthetists. At least one hospital-employed nurse anesthetist is assigned to each room. The four anesthesiologists employed by Roux and Associates travel between the rooms as they are needed for supervision. Anesthesia is routinely administered by the nurse anesthetist. An anesthesiologist remains with a patient only for more complicated operations. Appellees aver that the system employed is in the best interest of quality patient care. The monitoring of specialized equipment and supervision of nurses can best be handled, in their estimation, by the closed group policy. This closed group policy also gives the hospital the continuous twenty-four hour a day coverage that is crucial in the event of an emergency.[2] Other arguments made to justify the policy are that it facilitates the use of operating rooms since no waiting for outside anesthesiologists

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as the provision deleted. Regardless of the existence of any exclusive contract between the parties at present, the hospital continues to maintain the type of closed group policy at issue here. There is no question, hence, but that this is indeed a live controversy.

[2] This point of justification is rebutted quite easily, however, since Dr. Kermit Roux, president of Roux and Associates, admitted that he would feel professionally bound to provide such coverage even in the absence of an exclusive contract. It was Dr. Roux, after all, who requested that the exclusive language in the contract be removed. At trial, Dr. Roux explained the reason for his request:

is necessary and that it wisely allows the responsibility for development and management of the department to be placed upon one individual with legal obligations to the hospital. Finally, the appellees assert that the closed group policy permits them to more closely monitor the professional standards employed by the department members.

After a trial on the merits, the district court ordered this suit dismissed. In the corresponding opinion, the

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Q The Judge asked you if in fact when the 1976 contract was negotiated and executed, you asked that the language calling for the exclusion of the other anesthesiologists be deleted from the contract.

A Yes, sir.

Q So that it would no longer be a part of the contract?

A Yes, sir. The reason we did that, there were a number of reasons. There was this other group that had requested to come practice there and led us to believe that some physicians preferred them to give their anesthetics. And if that were true, then I think they should be allowed to practice.

The other reason is pretty much what you have alluded to, I didn't want to be there on the basis of hiding behind a contract. If I couldn't provide the service as best I could, then someone else ought to have a shot at it.

And I had been told by people a number of times that, you're hiding behind the contract because it gives you exclusive privileges "exclusive privileges" and doesn't let anyone else come. And I don't believe that that's the way medicine should be practiced. It should be practiced on the basis of the person whom the physician or the patient feels can do the best job, should be their physician.

So, we finally got them to delete that part of the contract.

Record on Appeal, vol. 3, at 7-8.

After this language was deleted, he continued to provide twenty-four hour a day coverage. Although the hospital's executive director testified that another provision, retained in the 1976 contract, had the same effect as the provision deleted, Dr. Roux did not operate under this interpretation of the contract.

court rejected a *per se* in favor of a rule of reason analysis of this case, stating in the alternative that plaintiff could not prevail on a *per se* analysis because he had not made the necessary demonstration that the hospital "dominated" the market for its services. The court held that relief was unavailable under a rule of reason analysis because the anticompetitive effects of the closed group policy were few and far outweighed by the many benefits to patient care. On appeal, Hyde argues that: (1) the tying arrangement involved is not immune from *per se* liability solely because of the professional nature of the services involved; (2) the district court erred in holding that the defendant hospital must be shown to have dominant power in the tying product market; and (3) the court incorrectly defined the relevant geographic market area for the tying product.[3]

TYING ARRANGEMENT

A tying arrangement is "an agreement by a party to sell one product but only on the condition that the buyer also purchases a different (or tied) product. . . ." *Northern Pacific Ry.* v. *United States*, 356 U.S. 1, 78 S.Ct. 514, 2 L.Ed.2d 545 (1958). The existence of a tying arrangement in this case has never been seriously disputed by appellees, since it is clear that users of the hospital's operating rooms (the tying product) are also compelled to purchase the hospital's chosen anesthesia service (the tied product). It is also clear that we are dealing with two distinct services which a buyer should be able to obtain

[3] Since we base our decision today exclusively on Section 1 of the Sherman Act, we do not unnecessarily recite the other portions of the lower court's judgment and appellant's challenges thereto.

separately. Our inquiry does not end here; tying arrangements are only proscribed by the Sherman Act when they exhibit the following four characteristics:

(1) two separate products, the tying product and the tied product;

(2) sufficient market power in the tying market to coerce purchase of the tied product;

(3) involvement of a not insubstantial amount of interstate commerce in the tied market; and

(4) anticompetitive effects in the tied market.

Bob Maxfield, Inc. v. *American Motors Corp.*, 637 F.2d 1033, 1037 (5th Cir. 1981). The United State Supreme Court recognized many years ago that "the vice of tying arrangements lies in the use of economic power in one market to restrict competition on the merits in another, regardless of the source from which the power is derived and whether the power takes the form of a monopoly or not." *Northern Pacific Ry.* v. *United States*, 356 U.S. at 11, 78 S.Ct. at 521.

The district judge ruled against appellant on precisely this point. He found that appellant had failed to demonstrate that the hospital dominated the market for its services. However, as the following language from the United States Supreme Court's opinion in *Northern Pacific Ry.* v. *United States, supra*, demonstrates, market domination is not required:

> While there is some language in the Times-Picayune opinion which speaks of "monopoly power" or "dominance" over the tying product as a necessary precondition for application of the rule of per se unreasonableness to tying arrangements, we do not

> construe this general language as requiring anything more than sufficient economic power to impose an appreciable restraint on free competition in the tied product (assuming all the time, of course, that a "not insubstantial" amount of interstate commerce is affected). To give it any other construction would be wholly out of accord with the opinion's cogent analysis of the nature and baneful effects of tying arrangements and their incompatibility with the policies underlying the Sherman Act. Times-Picayune, of course, must be viewed in context with International Salt and our other decisions concerning tying agreements.

Id. at 11, 78 S.Ct. at 521.

Although appellant is correct in his assessment of the economic power necessary to sustain a finding of an illegal tying arrangement, the court's imperfect definition of the relevant geographic market for the hospital's services would prevent him from succeeding on this element, even when a less stringent economic power standard is applied. The court below made the following finding about the relevant geographic market area:

> A relevant geographic market is the market area in which the seller operates and to which the purchaser can practically turn for supplies. The evidence showed that 70% of the patients from the East Bank of Jefferson Parish go to hospitals in the metropolitan Orleans area other than East Jefferson. The data presented by the New Orleans Area/ Bayou River Health System shows large numbers of Jefferson residents go to hospitals in the New Orleans area such as Mercy, Baptist and Touro Hospitals and Hotel Dieu. Therefore plaintiff must show

> that East Jefferson dominated the market which at least includes the Orleans Parish hospitals which are located on the East Bank.

Record on Appeal, vol. 2, at 246-47.

The court applied a traditional method of economic power analysis in this case, recognizing that surgeons have the option of admitting their patients to other hospitals and that patients have a similar right to go to another hospital if they are at all dissatisfied with the anesthesia service offered at East Jefferson Hospital. The contract at issue here involved only one hospital out of at least twenty in the area. Under the analysis applied to a truly competitive market, appellant has failed to prove an illegal tying arrangement. In *U.S. Steel* v. *Fortner Enterprises*, 429 U.S. 610, 97 S.Ct. 861, 51 L.Ed.2d 80 (1977), the Supreme Court framed the inquiry as

> whether the seller has the power, within the market for the tying product, to raise prices or to require purchasers to accept burdensome terms that could not be exacted in a completely competitive market. In short, the question is whether the seller has some advantage not shared by his competitors in the market for the tying product.
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> Without any such advantage differentiating his product from that of his competitors, the seller's product does not have the kind of uniqueness considered relevant in prior tying-clause cases.

Id. at 620-21, 97 S.Ct. at 867-68 (footnotes omitted).

Not only the court defined market power standard, but also the area within which the court finds that power operates, determine the extent of the hospital's actual

power. If both patient and surgeon are free to go to any one of a large number of competent institutions, from whence, appellees ask, does the hospital derive the power to force the tied product upon consumers?

The foregoing analysis assumes that the health care industry functions as a competitive market in the same sense as the industries involved in the plethora of other tying cases and should be subject to the same standards.[4] This is not correct. Several market imperfections in the health care industry favor public, non-profit entities like East Jefferson Hospital. First, the prevalence of third party payment of bills eliminates a patient's incentive to compare the relative cost effectiveness of competing hospitals. A second market imperfection is the lack of complete information regarding the quality of medical care offered. Since a patient cannot realistically compare the quality of medical care, he is likely to purchase his medical care from a non-profit entity that has no apparent profit motive to cut quality. It is not surprising that these factors lead patients to select the hospital closest to home, a preference which the court below noted:

> It is likely that any individual will choose to go to the hospital closest to his home if it is possible to do so for the convenience of the family. Persons living nearer to hospitals in other areas will choose to go these hospitals if possible.

Record on Appeal, vol. 2, at 247-48.

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[4] *See, e.g., U.S. Steel* v. *Fortner*, 429 U.S. 610, 97 S.Ct. 861, 51 L.Ed.2d 80 (1977); *Northern Pacific Ry.* v. *United States*, 356 U.S. 1, 78 S.Ct. 514, 2 L.Ed.2d 545 (1958); *International Salt Co.* v. *United States*, 332 U.S. 392, 68 S.Ct. 12, 92 L.Ed. 20 (1947); *IBM Corp.* v. *United States*, 298 U.S. 131, 56 S.Ct. 701, 80 L.Ed. 1085 (1936).

The fact that patients tend to choose hospitals by location rather than price or quality, means that the geographical market area for each hospital is much smaller than the district court found. In this case, the court below, while recognizing in one breath patients' preference for hospitals close to home, required appellant to show the economic power of the hospital in a large market area which includes at least twenty other hospitals. We cannot reconcile the judge's findings here; we conclude, therefore, that the judge erred when he defined the geographical market area.[5] Since nearly one-third of the patients from the entire East Jefferson Area go to East Jefferson Hospital, we hold that the hospital does have sufficient market power in the tying market to coerce purchase of the tied product. The propriety of holding that the relevant geographical market area is the East Bank of Jefferson Parish is further shown by the limitation placed on the East Jefferson Hospital Board by state law to serve only the East Bank of Jefferson Parish. The Hospital Board is directed by La.R.S. 46:1055 "[t]o represent the public interest in providing hospital and medical care *in the district.*"

In the course of presenting his case that the exclusive contract between the hospital and Roux and Associates violates the Sherman Anti-Trust Act, Dr. Hyde pointed out a number of "anticompetitive" effects that flow from the agreement. Basic to a discussion of these effects is an understanding of the manner in which the specialty of anesthesiology is practiced. Although the

[5] Amicus curiae, the Louisiana Medical Society, properly points out that this is not the figure which is important for this case. The court should have determined the geographic market in which the hospital competes for the provision of *surgical* facilities. In light of our resolution of the geographic market issue, however, we need not remand the case for a more specific finding.

specialty of anesthesiology is indeed a very important and demanding one, the anesthesiologist is only involved in the medical decision-making process after the initial decision between patient and surgeon that surgery is the indicated course of treatment.[6] It is not surprising, therefore, that an anesthesiologist is normally selected by the surgeon, rather than the patient, based on familiarity gained through a working relationship. Obviously, the surgeons who practice at East Jefferson Hospitals do not gain familiarity with any anesthesiologists other than Roux and Associates. Dr. Hyde argues that his is an especially egregious case because he has a more personal relationship with a great number of his patients than many anesthesiologists. This is because he specializes in obstetric anesthesiology and, more particularly, the administration of epidural anesthetics. The exclusive contract, therefore, prohibits patients as well as surgeons from selecting him. Another twist which is important to an understanding of the specialty, anesthesiologists have been confronted with the growth of a paraprofessional counterpart—the anesthetist. Herein lies the actual basis for the hospital's actions in this case.[7] While it is true that the tying of anesthesia services to operating rooms in the instant case did not lead to a higher charge for anesthesia services, it accomplished just as dramatic an effect by

[6] We recognize that anesthesiologists do work with specialists other than surgeons. However, the vast majority of their work is done in conjunction with surgery; this is the basis for our generalization.

[7] The district judge's determination that strictly quality considerations led the hospital to enter into an exclusive contract is clearly erroneous. Doctor Roux even testified as to the invalidity of the major justification put forth by the hospital. The district court's finding leaves this Court with the clear conviction that a mistake has been committed and is, for that reason, set aside.

increasing the hospital's profit. The hospital realizes a substantial profit from its practice of supplementing a small contract group of anesthesiologists with a much larger group of lower priced anesthetists. Furthermore, this practice lacks candor; the patient is not informed that he will be billed for the services of an anesthesiologist who may have had very little contact with his case.[8]

The exclusive contract spawns a number of anticompetitive effects.[9] First, the tie prevents anesthesiologists from entering that part of the anesthesia services market which the hospital controls. This prohibition of competition not only serves indirectly to artificially limit the number of anesthesiologists in the area, but, more importantly, it reduces the incentive for improving or initiating techniques or procedures. Quality is lowered by this restraint while at the same time the hospital's profit, as demonstrated above, is raised. In the instant case, there was also testimony that the profit motive caused the hospital to hire nurse anesthetists in place of needed anesthesiologists, a practice which dilutes the professional coverage available. Secondly, the tie eliminates the surgeon or patient's choice of anesthesiologist at this hospital. Since one goal of antitrust law is to allow the consumer to make buying decisions

[8] This discussion is by no means intended to denigrate the competence of nurse anesthetists. We simply make note of the all too common practice of an anesthetist performing services which are later billed by an anesthesiologist.

[9] Appellees contend that this contract does not stifle competition, but simply places the competition at a different point. They state that anesthesiology groups compete for this contract, and this ensures high quality and reasonable price for the services. We make no comment on the merits of this assertion because the hospital, in fact, has not permitted this competition since the original contract was signed over ten years ago.

without being subject to economic coercion, this anticompetitive effect is significant in a market where location tends to govern the choice of hospital.[10]

Despite the *per se* characterization of this arrangement, appellees maintain that the business justifications for the contract should insulate them from liability. This Court has recognized such a limited defense in tying arrangement cases, but appellees misstate its scope. An illegal tying arrangement will never be excused if there is a less restrictive way to accomplish the end which the business justification purports to serve. *Carpa, Inc.* v. *Ward Foods, Inc.*, 536 F.2d 39, 47 (5th Cir. 1976). The hospital's justifications for the contract must be examined in this light. A major justification for the contract—to insure continuous coverage—must be eliminated because Dr. Roux testified that he would provide twenty-four hour a day service without a contract. The argument that the contract facilitates the use of operating rooms must also be rejected, since appellees are unable to demonstrate why there is more lag time when

[10] The fourth element necessary to prove an illegal tying arrangement requires a finding of the amount of interstate commerce involved. A finding that "a total amount of business, substantial enough in terms of dollar-volume so as not to be merely *de minimis*, is foreclosed to competitors by the tie. . .," *Fortner Enterprises* v. *United States Steel Corp.*, 394 U.S. 495, 501, 89 S.Ct. 1252, 1258, 22 L.Ed.2d 495 (1969), will satisfy this test. The director of operating rooms at East Jefferson Hospital testified at trial that approximately 875 operations per month were performed at the hospital. Record on Appeal, vol. 2, at 236. Even if one uses the very conservative figure of $100 for anesthesia services, the sum of commerce foreclosed in a year's time amounts to over a mill n dollars. The district court recognized that a significant portion of the sum came through the channels of interstate commerce. The court also noted that supplies and medicine for the department are often provided by out-of-state sellers. Record on Appeal, vol. 2, at 240-41. We leave this finding undisturbed.

additional anesthesiologists are permitted to practice at the hospital. Similarly, the business justification based on the use of specialized equipment and nurse supervision must also fall since appellees fail to successfully bear the burden of demonstrating the superior ability of the closed group in this regard. Any anesthesiologist who sought to practice at this hospital would still have to be approved by the medical staff. This procedure was set up, after all, to screen out the incompetent doctors unable to handle such tasks. Monitoring of the professional competence of the anesthesiologists, another asserted business justification, can be accomplished by the much less restrictive means of relying upon the medical staff, which is already set up to provide this service. The need to place the responsibility for development and management of the department upon one individual can also be accomplished without an exclusive contract. In sum, appellees have failed to provide this Court with one reason for the exclusive contract which could not be resolved by a much less drastic solution.

Per Se Liability

Although this practice must be properly characterized as an illegal tying arrangement, appellees argue for a rejection of the stringent *per se* rule of liability traditionally applied in such cases. As justification for this departure from established precedent, they assert that since the judiciary has had little antitrust experience in the health care industry, a rule of reason approach is preferable.[11] They also contend that the professional

[11] In *Chicago Board of Trade* v. *United States*, 246 U.S. 231, 38 S.Ct. 242, 62 L.Ed. 683 (1918), Justice Brandeis set forth the following classic statement of the rule of reason:

> The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or

nature of the services mandates a rejection of the rigid *per se* rule. The Supreme Court's recent opinion in *Arizona* v. *Maricopa County Medical Society*, —— U.S. ——, 102 S.Ct. 2466, 73 L.Ed.2d 48 (1982), however, forecloses both arguments. That decision dealt with the *per se* rule as applied to price-fixing in the health care industry; its rationale is equally applicable to tying arrangements.[12]

> Nor does the fact that doctors—rather than nonprofessionals—are the parties to the price fixing agreements support the respondents' position. In *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, 788, n.17 [95 S.Ct. 2004, 2013, n.17, 44 L.Ed.2d 572] (1975), we stated that the "public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently." See *National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 696 [98

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whether it is such as may suppress or even destroy competition. To determine that question the court must ordinarily consider the facts peculiar to the business to which the restraint is applied; its condition before and after the restraint was imposed; the nature of the restraint and its effect, actual or probable. The history of the restraint, the evil believed to exist, the reason for adopting the particular remedy, the purpose or end sought to be attained, are all relevant facts. This is not because a good intention will save an otherwise objectionable regulation or the reverse; but because knowledge of intent may help the court to interpret facts and to predict consequences.

Id. at 238, 38 S.Ct. at 244.

[12] The courts have declared the following practices unlawful in and of themselves and, therefore, subject to the *per se* rule: price fixing, division of markets, groups boycotts, and tying arrangements. *Northern Pacific Ry. Co.* v. *United States*, 356 U.S. 1, 5, 78 S.Ct. 514, 518, 2 L.Ed.2d 545 (1958).

S.Ct. 1355, 1367, 55 L.Ed.2d 637] (1978). The price fixing agreements in this case, however, are not premised on public service or ethical norms. The respondents do not argue, as did the defendants in *Goldfarb* and *Professional Engineers*, that the quality of the professional service that their members provide is enhanced by the price restraint. The respondents' claim for relief from the *per se* rule is simply that the doctors' agreement not to charge certain insureds more than a fixed price facilitates the successful marketing of an attractive insurance plan. But the claim that the price restraint will make it easier for customers to pay does not distinguish the medical profession from any other provider of goods or services.

We are equally unpersuaded by the argument that we should not apply the *per se* rule in this case because the judiciary has little antitrust experience in the health care industry. The argument quite obviously is inconsistent with [*U.S.* v.] *Socony-Vacuum* [*Oil Co.*, 310 U.S. 150, 60 S.Ct. 811, 84 L.Ed. 1129]. In unequivocal terms, we stated that, "[w]hatever may be its peculiar problems and characteristics, the Sherman Act, so far as price-fixing agreements are concerned, establishes one uniform rule applicable to all industries alike." 310 U.S., at 222 [60 S.Ct. at 843]. We also stated that "[t]he elimination of so-called competitive evils [in an industry] is no legal justification" for price fixing agreements, *id.*, at 220, [60 S.Ct. at 843] yet the Court of Appeals refused to apply the *per se* rule in this case in part because the health care industry was so far removed from the competitive model. Consistent with our prediction in *Socony-Vacuum*, *id.*, at 221 [60 S.Ct. at 843] the result of this reasoning was the adoption by the Court of Appeals of a legal standard based on the reasonableness of the

fixed prices, an inquiry we have so often condemned. Finally, the argument that the *per se* rule must be rejustified for every industry that has not been subject to significant antitrust litigation ignores the rationale for *per se* rules, which in part is to avoid "the necessity for an incredibly complicated and prolonged economic investigation into the entire history of the industry involved, as well as related industries, in an effort to determine at large whether a particular restraint has been unreasonable—an inquiry so often wholly fruitless when undertaken." *Northern Pac. R. Co.* v. *United States, supra*, [356 U.S.] at 5 [78 S.Ct. at 518].

102 S.Ct. at 2475-77.

Similarly unpersuasive to the Supreme Court in *Arizona* v. *Maricopa County* was defendant's principal argument that the agreements should be immune from *per se* liability because of the procompetitive justifications therefor, an argument which is urged strenuously in this appeal.[13] The asserted procompetitive justifications for the exclusive contract between the hospital and

[13] The Court concluded that this argument was more properly directed to Congress:

> Our adherence to the *per se* rule is grounded not only on economic prediction, judicial convenience, and business certainty but also on a recognition of the respective roles of the Judiciary and the Congress in regulating the economy. *United States* v. *Topco Associates, Inc., supra*, [405 U.S. 596] at 611-612 [92 S.Ct. 1126 at 1135, 31 L.Ed.2d 515]. Given its generality, our enforcement of the Sherman Act has required the Court to provide much of its substantive content. By articulating the rules of law with some clarity and by adhering to rules that are justified in their general application, however, we enhance the legislative prerogative to amend the law. The respondents' arguments against application of the *per se* rule in this case therefore are better directed to the legislature. Congress may consider the exception that we are not free to read into the statute.

Roux and Associates are identical to the business reasons which were proposed to justify the contract. The following quote demonstrates why the procompetitive justifications offered by appellees do not warrant a departure from the *per se* rule.

> The argument indicates a misunderstanding of the *per se* concept. The anticompetitive potential inherent in all price fixing agreements justifies their facial invalidation even if procompetitive justifications are offered for some. Those claims of enhanced competition are so unlikely to prove significant in any particular case that we adhere to the rule of law that is justified in its general application. Even when the respondents are given every benefit of the doubt, the limited record in this case is not inconsistent with the presumption that the respondents' agreements will not significantly enhance competition.

102 S.Ct. at 2477 (footnote omitted).

CONCLUSION

Inasmuch as we declare that this exclusive contract creates an illegal tying arrangement, we must also grant the requested injunction and permit Dr. Hyde to practice his chosen profession. The medical staff at East Jefferson Hospital highly recommended that he be granted staff privileges.[14] The refusal of the hospital board to grant staff privileges was based on the existence of the exclusive contract with Roux and Associates.

Id. 102 S.Ct. at 2478-79 (footnote omitted).

[14] We concur with the following statement from *Sosa* v. *Board of Managers of Val Verde Hospital*, 437 F.2d 173 (5th Cir. 1971), about the propriety of judicial restraint where the professional and ethical competence of a physician is concerned.

> In the instant case there was considerable evidence regarding Dr. Sosa's ethical and professional competency. No court should

This opinion does not test the limits of access to staff privileges. Certainly, the staff size of each hospital is bounded by legitimate concerns of overcrowding, overtaxing of hospital personnel and resources, and the consequent decline in quality of patient care. In the instant case, however, it was not the size of the department which concerned the hospital board, but the profit which the current structure generated. In addition, the concerns which allegedly led to the implementation of the exclusive contract can be addressed by much less restrictive alternatives. They furnish an illusory basis for depriving a physician of the right to practice his profession.

For the reasons set forth above, the district court's judgment in this matter is reversed.

REVERSED.

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substitute its evaluation of such matters for that of the Hospital Board. It is the Board, not the court, which is charged with the responsibility of providing a competent staff of doctors. The Board has chosen to rely on the advice of its Medical Staff, and the court cannot surrogate for the Staff in executing this responsibility. Human lives are at stake, and the governing board must be given discretion in its selection so that it can have confidence in the competence and moral commitment of its staff.

Id. at 177.

APPENDIX B

DR. EDWIN G. HYDE

v.

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 And THE EAST JEFFERSON HOSPITAL BOARD.

Civ. A. No. 78–750.

UNITED STATES DISTRICT COURT,
E. D. LOUISIANA.

Jan. 23, 1981.

MITCHELL, District Judge.

This matter was tried to the Court on a former date. The Court now makes the following written findings of fact and conclusions of law in accordance with Rule 52(a) of the Federal Rules of Civil Procedure.

FINDINGS OF FACT

I.

Plaintiff, Dr. Edwin G. Hyde, is a medical doctor, licensed to practice by the State of Louisiana. Dr. Hyde is board certified in anesthesiology and is engaged in the practice of that specialty, primarily doing obstetric work at Lakeside Hospital in Metairie, Louisiana.

II.

Defendant Jefferson Parish Hospital District No. 2 (hereinafter the District) is a political subdivision of the State of Louisiana, created by the Jefferson Parish Council in accordance with the provisions of La.R.S.

46:1051 et seq. The District owns East Jefferson General Hospital (hereinafter East Jefferson) which was constructed with public monies. The Jefferson Parish Council is the governing authority of the District and has delegated its responsibility to operate East Jefferson to a twelve man Board of Directors (hereinafter the Board) which has the ultimate responsibility for the quality of medical care provided by the hospital. The Board appoints an executive director to carry out its policies in the daily operations of the hospital. Mose Ellis has been employed as the Executive Director of the hospital since January, 1968 which was prior to the hospital's construction.

III.

The by-laws of East Jefferson Hospital provide for the appointment of a separate body, the Medical Staff, which consists of the heads of various medical departments in the hospital. The Medical Staff develops its own set of rules and by-laws, which are subject to ratification by the Board.

Physicians applying for medical staff privileges must submit an application to the hospital director. The accuracy of the information given is checked by hospital employees and the application is then forwarded to the Credentials Committee of the Medical Staff for review of the applicant's qualifications. That Committee then makes a recommendation to the Medical Executive Committee which in turn makes a recommendation to the Board of Directors.

Pursuant to the by-laws of the hospital and the medical staff the Board makes the ultimate determination with regard to the appointments of physicians to the

medical staff with the limitation that it must make its choices from physicians who receive recommendations from the medical staff.

IV.

East Jefferson entered into a contract with Roux & Associates, a professional medical corporation, to provide anesthesia services to the hospital prior to its opening in February, 1971. The contract provided that the anesthesia services would be exclusively provided by Roux and Associates and that members of the group would not provide its services elsewhere without the written authorization of the hospital. The Board felt that a closed group policy was in the best interest of quality patient care. Ellis testified that it was determined that a closed system would be more advantageous because anesthesiology is a hospital based specialty and the Board was of the opinion that the responsibility for the development and management of the department should be placed upon one individual with legal obligations to the institution. Other reasons given for choosing that system were that the supervision of some twenty nurses and the monitoring of specialized equipment could best be handled by one individual or group always present at the hospital. The hospital felt it necessary to have a group on call for twenty-four hours a day so that it could be assured of the presence of a physician in the event of an emergency arising. The closed system would also facilitate the scheduling of operations and result in a more efficient use of operating rooms since there would be no delay while waiting for outside anesthesiologists to arrive. The Board also felt a closed system would allow them to closely monitor the medical standards employed by the members of their department. The medical staff was well satisfied with the system under

Roux and Associates and the Board wished to continue under the same conditions. Ellis stated that a patient was free to go to another hospital if he desired to use a particular anesthesiologist who is not on East Jefferson's staff.

V.

The hospital entered into a second contract with Roux and Associates in January 1976. At Dr. Roux's request the language designating the contract as an exclusive one was omitted. However, in another section, the contract continued to provide that all anesthesia services at the hospital were to be provided by the Roux group. Ellis stated that at no time did the Board express an intent to change its policy with regard to the closed system. Ellis had no firsthand knowledge of the Roux doctors practicing elsewhere though he had heard rumors that such was occurring. Ellis stated that doctors who are not on the East Jefferson medical staff could apply for temporary privileges to practice on a case by case basis.

VI.

Ellis testified that the hospital charges patients one fee for the professional services rendered by the anesthesiologist and for the anesthesia services provided by the hospital. The hospital pays the salaries of the nurses and purchases the equipment and supplies for the anesthesia department. A large number of the supplies are purchased from out of state. It also provides housekeeping, record keeping and maintenance services to the department.

The anesthesiologist determines the fee for the anesthesia service provided dependent upon the complexity and length of the operation performed. The hospital

deducts 8% for bad debts, charity and other write offs from the gross receipts of the department and 50% of the remainder is paid to Roux and Associates for its professional services. Ellis testified that it was in accord with hospital industry practice to pay hospital based specialists a certain percentage of the receipts. Ellis also testified that the anesthesiology department generally made a profit but that the purpose of the closed anesthesiology department was to provide quality patient care and not for the financial profit of the hospital.

Ellis testified that anesthesia services were often paid in part by federal medicare and medicaid benefits.

VII.

Dr. Kermit Roux formed Roux and Associates in 1970 and began work at East Jefferson in 1971. Roux testified that he requested the omission of the exclusive language in his 1976 contract because he believes a surgeon or patient is entitled to the services of the anesthesiologist of his choice. He admitted that he and others in his group did work outside East Jefferson following the 1976 contract but felt he was not in violation of the contract in light of the changes made in it.

Roux testified that he employed three other doctors in his group and that there are usually thirteen or fourteen certified registered nurse anesthetists (CRNA's) on duty during operations. CRNA's are registered nurses with two years training as anesthetists. They are used in every hospital in the New Orleans area because there are more hospitals than anesthesiologists in Louisiana.

Dr. Roux testified that the anesthesiologist prescribes the anesthetic to be given and the equipment to be used. The doctor administers the drugs and remains in the operating room until he is confident the patient is in

stable condition. He then goes to another operating room leaving the nurse to monitor the patient. The doctor again checks the patient in the recovery room. In Roux's opinion neither the hospital nor its nurses are engaging in the practice of medicine.

Roux was unaware of any complaints being made about his group's services.

VIII.

Dr. Edwin Hyde submitted an application for medical staff privileges to the hospital on July 14, 1977. The Credentials Committee approved his credentials and qualifications and referred the application to the Medical Executive Committee which considered his qualifications and forwarded his application to the Board of Directors with a recommendation of approval.

A Board of Directors meeting was held on September 20, 1977 and the minutes reflect there was discussion with regard to the application of Dr. Hyde to the anesthesiology department. It was noted that Hyde would not be a member of the Roux and Associates group and a motion was made to table the application for further study.

A Board meeting was held on October 18, 1977 and the Hyde application was presented for action. The Board denied the application after a discussion with regard to the benefits of an exclusive contract with hospital based specialists and the Board concluded that a closed system was in the best interest of the hospital and quality patient care.

Ellis wrote Dr. Hyde on October 19, 1977 and informed him that he had not been accepted for medical

staff membership due to the exclusive nature of the contract between the hospital and Roux and Associates and because there were no openings in the Department of Anesthesia. Ellis stated that in giving the second reason he meant that Dr. Roux had no membership openings in his group.

Dr. Hyde was not told of any right to appeal his decision nor provided with a copy of the hospital's by-laws.

IX.

Dr. Charles Eckert is an anesthesiologist employed by Roux and Associates. He also did some work at Lakeside Hospital in 1977 and 1978. Eckert wrote a letter of recommendation to East Jefferson on Dr. Hyde's behalf. It is his opinion that a patient should be given the right to choose his anesthesiologist.

Eckert stated that the Roux group had requested that the exclusive language be removed from its contract because the group was being criticized by their peers for acting unethically.

However, other than that criticism, Eckert stated there had been no other problems with the closed anesthesiology department which is a common practice in the majority of hospitals in the area. He believes such a department is advantageous because the same individuals are working together daily as a team and the technicians learn to anticipate the manner in which the doctors proceed. Eckert also was of the opinion that it provides flexibility in the scheduling of operating rooms because the hospital does not have to postpone activity while waiting for another group to arrive. It is also easier to have one group operate and maintain the equipment used since they are immediately aware of any problems

and can have them remedied. Eckert stated that members of his group had used Lakeside's equipment without any difficulty but that it is not as complex as the equipment used at East Jefferson where more difficult surgeries are performed.

Eckert testified that there are one hundred fifty-six anesthesiologists in Louisiana and three hundred forty-five hospitals with operating rooms. He testified that in order to have an anesthesiologist present at every operation, East Jefferson would have to employ more than twelve anesthesiologists on its staff.

X.

Mrs. Melvaize Tedeschi is the Director of Operating Rooms at East Jefferson Hospital. She stated that the hospital performs approximately 875 operations per month. She testified that there are generally twelve or thirteen operating rooms in use at one time and four anesthesiologists working. Tedeschi is of the opinion that the nurses are well mointored and has heard many compliments given to the Roux group. She is of the further opinion that if there were outside anesthesiology groups working at the hospital it would decrease the flexibility in scheduling of operations. She also pointed out that if an operation was cancelled there might be a waiting period until the next doctor arrives.

XI.

Dr. John Rourke has been a member of the East Jefferson Board since it was formed. He testified that the Board always assumed that certain departments would be administered by a single group which would develop that department.

Rourke stated that he knew that at one point Touro Hospital had used two separate groups and had experienced problems with competitiveness between those groups. The problems began because the surgeons would generally give priority to one group and he would then have problems dealing with the other group because they felt they were second choice. Touro eventually entered into a contract with one group.

Rourke stated that problems arise because the physicians all want to begin at the same time and also in the absence of a contract there may not be an anesthesiologist available in an emergency situation, thus placing a patient's health at risk.

Rourke stated the Board and staff were pleased with the work of the Roux group and wanted to continue to have a contract with them to guarantee their availability and the best patient care.

Dr. Rourke testified that a patient is paying a medical fee for the expertise of the anesthesiologist in prescribing the drugs used and performing complex procedures. He stated that the nurses merely monitor the patient's progress during the operation and are not making critical medical determinations.

Dr. Rourke stated that East Jefferson is not a charity hospital and the hospital's operating revenues are obtained from the patient's payments for services rendered. It is a public hospital because it was constructed with community funds.

XII.

Nicholas Gagliano has also been a member of the Board of Directors since the inception of the hospital.

He testified that the Board has had continued input from the medical staff with regard to the merits of the closed system anesthesiology department and that the Board has re-evaluated its policy and has continued to find that the closed system is the best manner to operate to insure the twenty-four hour availability of quality anesthesia services.

He testified that the hospital has informed the Roux group that it is in violation of its contract to practice elsewhere.

XIII.

Dr. John Andriani has been practicing anesthesiology at Charity Hospital for forty years. He organized the CRNA training program and established the anesthesiology residency at Charity.

Dr. Andriani testified that he is opposed to the closed anesthesiology departments because a patient loses a right to select the anesthesiologist of his choice and also causes competent physicians to lose jobs. He opined the lack of competition within a hospital will discourage the group with the exclusive contract from improving or initiating new techniques and procedures. Andriani also believes that the closed system discourages anesthesiologists from coming to New Orleans and medical students from entering the field because of a lack of positions in this area.

Andriani is also of the opinion that the hospitals are employing CRNA's and improperly charging patient's medical fees for their services. He believes that one anesthesiologist should supervise no more than three and at most four nurses during operations.

XIV.

Dr. Edwin Hyde practiced anesthesiology in Florida and at Baptist Hospital, New Orleans, for seven years prior to joing the staff at Lakeside Hospital in 1971. He is associated with two other anesthesiologists at Lakeside. However, Lakeside Hospital has an open department and other anesthesiologists regularly practice there. Hyde testified that a booking secretary schedules the Lakeside operations and there is no problem with outside anesthesiologists coming in to work. He stated that similar systems had worked in the Florida hospital where he worked and at Baptist Hospital without any difficulties.

Hyde does not have a contract with Lakeside Hospital. He bills his patients separately and his group employs its own nurses. The hospital has a maintenance contract on the equipment and any problems with it are reported to Hyde since he is the chairman of the Department. Hyde stated that this system operates without any problems.

Hyde stated that he would continue his separate billing procedure at East Jefferson but would only bring his own nurses if he was doing a complex surgery. The majority of his work at Lakeside is obstetrics and he feels he could attract more doctors to his group if he could do different types of surgery at another hospital. He is of the opinion that exclusive contracts discourage anesthesiologists from coming into the area because they limit the openings at hospitals.

XV.

Jessie Smallwood, executive director of the Bayou River Health Systems presented data showing which hospitals the patients residing in certain zip code areas

attend over various time periods. Her information was incomplete because at various times certain hospitals did not participate in the surveys. There is also no information with regard to which patients had surgery.

The data showed that approximately seventy per cent (70%) of the patients who are residents of Jefferson Parish entered hospitals located in the metropolitan New Orleans area other than East Jefferson. Seventy per cent (70%) of the patients entering East Jefferson are residents of East Bank Jefferson Parish. Several hundred patients from out of state were admitted to East Jefferson Hospital in 1978 and 1979.

XVI.

Based on the evidence presented the Court concludes that the Board of Directors was acting within its statutory authority under state law and the hospital's by-laws in not adopting the medical staff's recommendation and denying Dr. Hyde medical staff privileges.

XVII.

The Court also finds that the portion of the anesthesia fees retained by the hospital bears a reasonable relationship to the services and materials provided by the hospital in connection with anesthesiology services.

The Court finds that the hospital did not improperly engage in the diagnosis and treatment of patients. The evidence shows that the anesthesia services are provided by the anesthesiologist who prescribes the drugs used and performs all procedures requiring expertise. The CRNA's work under the supervision of the anesthesiologists and their function is to monitor the patients while they are anesthetized.

XVIII.

The evidence shows that in the operation of its anesthesia department the defendants are involved in activities which have a not insubstantial effect on interstate commerce. These include buying anesthesia medicines and other supplies from out of state, the receipt by patients of federal medicare and medicaid benefits to pay for anesthesia services and the treatment of out of state patients who require anesthesia services.

XIX.

The evidence presented was that it is a common practice in the health care industry for hospitals to enter into exclusive contracts with physicians who are engaged in certain hospital based specialties, such as anesthesiology, radiology, pathology, etc. to insure the availability of these services to their patients. Generally a patient does not specifically select a certain individual to perform these services, which increases the hospital's responsibility to insure the quality of services it provides.

The evidence presented was that defendants instituted a closed system anesthesiology department because they believed the system resulted in the best quality of patient care. Specifically the system insures twenty-four hour anesthesiology coverage, aids in the control and standardization of procedures and the efficient and less costly operation of the department; it lends flexibility to the scheduling of operations because it is not necessary to accommodate physicians with outside commitments; it permits the physicians, nurses and other technicians in the department to develop a work routine and a proficiency with the equipment they use in patient treatment; and it increases the Board's

ability to monitor the medical standards exercised because there are fewer individuals involved, maintenance of equipment is simplified and equipment breakdowns are minimized by limiting use to one group of physicians.

The Court does not find that the Board's motive in continuing the closed system is purely a pecuniary one. If that was its only motive it could retain a contract with one group continuing its present billing procedure and still allow other anesthesiologists to come in to practice. It appears to the Court that the Board feels that the closed system department is the best to employ to carry out their obligation to the public to offer the highest quality of medical care.

The Court concludes that the benefits discussed above support a finding of reasonableness that justifies the exclusive arrangement between the defendants and Roux and Associates.

XX.

The provision of anesthesia services is a medical service separate from the other services provided by the hospital. The hospital charges the patient a separate charge for this service.

The geographic area in East Jefferson competes in the New Orleans metropolitan area. Large numbers of patients from Jefferson Parish use the hospitals in Orleans Parish. Seventy per cent (70%) of the patients living in East Bank Jefferson Parish go to hospitals other than East Jefferson. The Court concludes that East Jefferson is competing for business at least with the hospitals located on the East Bank in Orleans Parish.

XXI.

The evidence presented did not show that East Jefferson had any advantages over any other hospitals in the area because it is a public hospital. Due to that fact (the hospital was built with public funds) however, it is not a charity hospital and its daily operations are financed by patients' payments for hospital services. There was no evidence presented that East Jefferson was in a position to charge patients higher prices or to impose burdensome terms which could not be exacted in a completely competitive market. There was no evidence that East Jefferson was a dominant economic power in the market in which it competes.

The impact on commerce resulting from the East Jefferson contract is minimal. The contract is restricted in effect to one hospital in an area containing at least twenty others providing the same surgical services. It would be a different situation if Dr. Roux had exclusive contracts in several hospitals in the relevant market. As pointed out by plaintiff, the majority of surgeons have privileges at more than one hospital in the area. They have the option of admitting their patients to another hospital where they can select the anesthesiologist of their choice. Similarly a patient can go to another hospital if he is not satisfied with the physicians available at East Jefferson.

A closed department may enhance competition among the hospitals in the market by increasing the quality of medical care available. It may also serve to benefit competition among anesthesiology groups if the terms of the exclusive contracts are not for unreasonable periods of time. Such a system would serve to encourage anesthesiologists to improve the quality of their services in order to obtain these contracts with hospitals.

The Court concludes that the purpose of the exclusive contract is to enhance patient care and its restraint on competition in the field of anesthesiology is minimal.

CONCLUSIONS OF LAW

I.

The Court has jurisdiction over this action pursuant to the provisions of 28 U.S.C. § 1337 and 28 U.S.C. § 1343(3) and pendant jurisdiction over the state law claims.[1] Venue is properly laid in this district.

II.

The Sherman Antitrust Act prohibits every contract, combination or conspiracy which unreasonably restrains trade or commerce among the several states.[2] It encompasses far more than restraints on trade that are motivated by a desire to limit interstate commerce or that have their sole impact on interstate commerce. Wholly local business restraints can produce the effects condemned by the Act as long as the activity is an inseparable element of a larger program dependent for its success upon an activity which affects commerce between the states.[3]

Although it may have an effect on the determination of a violation of the Sherman Act, neither the nature of

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[1] *United Mine Workers v. Gibbs*, 383 U.S. 715, 86 S.Ct. 1130, 16 L.Ed.2d 218 (1966).

[2] 15 U.S.C. § 1.

[3] *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, 95 S.Ct. 2004, 44 L.Ed.2d 572 (1975); *Gulf Oil Corporation* v. *Copp Paving Company*, 419 U.S. 186, 95 S.Ct. 392, 42 L.Ed.2d 378 (1975); *United States* v. *Employing Plasterers Association*, 347 U.S. 186, 74 S.Ct. 452, 98 L.Ed. 618 (1954).

an occupation nor the public service aspect of a professional practice is controlling in determining whether or not the Act initially applies.[4] The payments exchanged for professional services constitute trade or commerce and, if the commerce involved is interstate in character, it is subject to the jurisdiction of the Sherman Act.[5]

A substantial effect on interstate commerce to satisfy the Act's jurisdictional requirements has been found in the health care field where the challenged activity has some effect on the purchase of out-of-state medicines and supplies, the receipt of federal medicare and medicaid benefits and the treatment of out-of-state patients.[6] The evidence presented showed that East Jefferson Hospital made these interstate contacts in the course of the operations of its anesthesia department and the Court finds that these contacts had a not "insubstantial effect" on interstate commerce. Therefore we find jurisdiction under the Sherman Act.

III.

Plaintiff contends that the defendants have established a "tying arrangement" by tying the purchase of

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[4] *Goldfarb* v. *Virginia State Bar, supra; National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 98 S.Ct. 1355, 55 L.Ed.2d 637 (1978); Horan and Nord, "Application of the Anti-trust Laws to the Health Care Delivery System", 9 *Cumberland Law Review*, 665 (1979).

[5] *Ballard* v. *Blue Shield of Southern W. Va., Inc.*, 543 F.2d 1075 (CA4–1976).

[6] *Hospital Building Company* v. *Trustees of Rex Hospital*, 425 U.S. 738, 96 S.Ct. 1848, 48 L.Ed.2d 338 (1976); *Boddicker* v. *Arizona State Dental Association*, 549 F.2d 626 (CA9–1977); *Zamiri* v. *William Beaumont Hospital*, 430 F.Supp. 815 (E.D.Mich.1977); *Feminist Women's Health Center, Inc.* v. *Mohammad*, 415 F.Supp. 1258 (N.D.Fla.1976).

anesthesia services to the provision of hospital surgical facilities and that such agreement is illegal per se. We are of the opinion that the per se rules used in anti-trust cases governing regular commercial activities should not be made automatically applicable to cases involving professional activities. This will be discussed later in the opinion. However, the Court will discuss the elements involved in determining whether or not the tying agreement is illegal per se in the event an appellate court should disagree on this issue, which involves a relatively new area of law.

An agreement by a party to sell one product but only on the condition that the buyer also purchases a different or tied product, or at least agrees that he will not purchase the product from any other supplier, is a tying agreement.[7] Such agreements serve hardly any purpose beyond the suppression of competition. Tying agreements are unreasonable in and of themselves whenever a party has sufficient economic power with respect to the tying product to appreciably restrain free competition in the market for the tied product and a "no insubstantial amount" of interstate commerce is affected.[8] Where a seller has no control or dominance over the tying product so that it does not represent an effective weapon to pressure buyers into taking the tied item, any restraint of trade attributable to such arrangement is insignificant [9] Indicia of economic power in the market is the

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[7] *Northern Pacific Railway Company* v. *United States*, 356 U.S. 1, 78 S.Ct. 514, 2 L.Ed.2d 545 (1958).

[8] *Spartan Grain & Mill Company* v. *Ayers*, 581 F.2d 419 (CA5–1978).

[9] *U. S. Steel* v. *Fortner Enterprises, Inc.*, 429 U.S. 610, 97 S.Ct. 861, 51 L.Ed.2d 80 (1977).

ability of the seller to raise prices or to impose burdensome terms on purchasers which could not be exacted in a completely competitive market.[10] Another indication would be the uniqueness of the tying product (surgical procedures) which prevents the competitors from offering an equivalent product or services.[11] A third sign is that a substantial number of purchasers have accepted this agreement and there is no explanation for it other than the economic power of the seller.[12]

A relevant geographic market is the market area in which the seller operates and to which the purchaser can practically turn for supplies.[13] The evidence showed that 70% of the patients from the East Bank of Jefferson Parish go to hospitals in the metropolitan Orleans area other than East Jefferson. The data presented by the New Orleans Area/Bayou River Health System shows large numbers of Jefferson residents go to hospitals in the New Orleans area such as Mercy, Baptist, and Touro Hospitals and Hotel Dieu. Therefore plaintiff must show that East Jefferson dominated the market which at least includes the Orleans Parish hospitals which are located on the East Bank. This plaintiff has failed to do. No evidence was presented that East Jefferson imposes any higher prices or imposes any more burdensome terms on its patients than other hospitals in the area. If the use of CRNA's in their anesthesia department is not a favorable procedure, it is one, according to the evidence, which is imposed by all hospitals in the area.

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[10] id.

[11] *Moore* v. *Jas. H. Mathews & Co.*, 550 F.2d 1207 (CA9–1977).

[12] id.

[13] *U. S.* v. *Phillipsburg National Bank & Trust Company*, 399 U.S. 350, 90 S.Ct. 2035, 26 L.Ed.2d 658 (1970).

It does not appear from the evidence that the fact that the hospital is a public one gives it any advantage over others in the area other than that it was built with public funds. It is not a charity hospital and patients pay the same fees as they would pay elsewhere. There was no evidence that the surgical procedures available at East Jefferson are not available at other area hospitals or that the others could not provide equivalent services.

Plaintiff dwells heavily on the fact that seventy (70%) per cent of East Jefferson's patients are residents of the East Bank of Jefferson Parish. It is likely that any individual will choose to go to the hospital closest to his home if it is possible to do so for the convenience of the family. Persons living nearer to hospitals in other areas will choose to go to those hospitals if possible. The Court does not find that this factor is proof that East Jefferson is a strong economic power in the market in which it competes.

Based on the above analysis, the Court rejects plaintiff's argument that the agreement involved herein is illegal per se.

IV.

The United States Supreme Court in *Goldfarb* v. *Virginia State Bar*,[14] rejected the idea of professional occupational exemption from the anti-trust laws but intimated that a different standard should be applied to professional services in a now often cited footnote. The Court stated:

> The fact that a restraint operates upon a profession as distinguished from a business is, of course, relevant in determining whether that particular restraint violates the Sherman Act. It would be unrealistic to view

[14] *Goldfarb* v. *Virginia State Bar, supra*, n.3.

> the practice of professions as interchangeable with other business activities, and automatically to apply to the professions anti-trust concepts which originated in other areas. The public service aspect may require that a particular practice, which could be properly viewed as a violation of the Sherman Act in another context, be treated differently.[15]

In light of that footnote the Court and commentators have suggested that the activities of professional groups should be analyzed according to the rule of reason even though the conduct might be considered a per se violation in another context.[16] Relying on the rule of reason, several courts have upheld the use of exclusive contracts in providing certain medical services to hospitals prior to the *Goldfarb* decision.[17]

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[15] Id. at 788–89, Footnote 17.

[16] *Boddicker* v. *Arizona State Dental Association, supra* at note 6; *Veizaga* v. *National Board for Respiratory Therapy*, 1977—1 Trade Cas. 61, 274 (N.D.Ill.1977); Tyler, "Goldfarb v. Virginia State Bar: The Professions Are Subject to the Sherman Act", 41 *Mo.Law Review*, 1, 11 (1976); "Application of the Antitrust Laws to Anticompetitive Activities by Physicians", 30 *Rutgers Law Review* 991 (1977), *see* Horan and Nord at note 4.

[17] *Datillo* v. *Tucson Gen. Hospital*, 23 Ariz. App. 392, 533 P.2d 700 (Ariz.App.1975) (exclusive contract to provide nuclear medicare services); *Letsch* v. *Northern San Diego County Hospital District*, 55 Cal.Rptr. 118, 246 Cal.App.2d 673 (1963) (closed radiology department held reasonable and lawful); *Blank* v. *Palo Alto Stanford Hospital Center*, 44 Cal. Rptr. 572 (1965) (exclusive contract with diagnostic x-ray department held reasonable and proper method of operating a department); *Benell* v. *City of Virginia*, 104 N.W.2d 633 (1960) (closed radiology department was not arbitrary or unreasonable but in furtherance of hospital's duty to operate efficiently and economically); also see *Radiology Prof. Corp.* v. *Trinidad Area Health*, 577 P.2d 748 (Colo.1978).

In post *Goldfarb* cases different types of analysis have been suggested in applying the rule of reason to professions. One Court held that in order to survive a Sherman Act challenge "a particular practice of a profession . . . must serve the purpose for which the profession exists, viz, to serve the public. That is, it must contribute directly to improving service to the public. Those which only suppress competition between practitioners will fail to survive the challenge."[18] Other factors to be considered are the motive underlying the challenged restraint, as well as the relative positive and negative effects, the powers of the parties on the market they serve and whether other less restrictive means could be employed to achieve the same desired results.[19]

The Supreme Court in its first post *Goldfarb* decision, *National Society of Professional Engineers* v. *U.S.*,[20] implied that the inquiry of the Court in applying the rule of reason is not directed toward the justification of the anticompetitive practice, but rather toward determining whether the challenged practice has an anticompetitive effect.

We have noted in our findings of fact that there are many benefits arising from the closed system which result in improved patient care. We do not believe that the motive behind the system is a pecuniary one, as suggested by plaintiff. Any profits made in the department are put back into the hospital. It is not a situation where a certain individual or group is benefiting financially from the system. The motive appears to be to

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[18] *Boddicker* v. *Arizona Dental Association, supra* at note 6.

[19] *Hennessy* v. *National Collegiate Athletic Assoc.*, 564 F.2d 1136 (CA5–1977).

[20] *National Society of Professional Engineers* v. *U. S., supra* at note 4.

continue a system which has resulted in the operation of a successful department providing excellent health care. An open department would result in a loss of several of the advantages flowing from the system discussed in our fact findings.

We also find that the anticompetitive effect on the practice of anesthesia in the relevant market area is minimal. The East Jefferson group does not enjoy a monopoly nor does it control a substantial share of the provision of services in the relevant area. As far as the Board is concerned the Roux group practice is limited to East Jefferson Hospital. The contract does not prevent Dr. Hyde or any other anesthesiologist from practicing in any hospital other than East Jefferson in the relevant market area. This Court tends to agree with the suggestion of a commentator [21] that "exclusive relationships, such as those between hospitals and certain speciality services, can properly be characterized as enhancing competition by improving a hospital's ability to provide competent health care competitively."

V.

The Louisiana anti-trust laws provide that every contract in restraint of trade or commerce is illegal.[22] In interpreting its anti-trust laws, the Louisiana courts have looked to the federal jurisprudence for guidance.[23]

We conclude that there has been no unreasonable restraint of trade under the federal laws and that there has been no restraint in violation of the state anti-trust laws.

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[21] See Horan and Nord, *supra* at note 4.

[22] La.R.S. 51:122.

[23] *Loew's Inc.* v. *Don George, Inc.*, 110 So.2d 553 (La.1959).

VI.

The operation of a public hospital, such as East Jefferson, constitutes state action and is subject to the requirements of the Fourteenth Amendment.[24]

The Fourteenth Amendment requires a public hospital to afford substantive due process to an applicant for admission to a medical staff.[25] Substantive due process requires the hospital to consider applicants only on grounds that are reasonably related to the purpose of providing adequate medical care.[26] Courts have found that exclusive contracts between a public hospital and some of its staff members to operate a certain specialized facility to the exclusion of other physicians equally qualified are not unreasonable or arbitrary and are justified if their object is to provide proper medical care to surgical patients.[27]

We conclude that the defendants entered into the exclusive contract with Roux and Associates in order to provide its patients with quality anesthesia services and therefore the requirements of substantive due process have been met.

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[24] *Woodbury* v. *McKinnon*, 447 F.2d 839 (CA5–1971).

[25] *Shaw* v. *The Hospital Authority of Cobb County*, 507 F.2d 625 (CA5–1975), affirmed on rehearing, 614 F.2d 946 (CA5–1980).

[26] *Sosa* v. *Board of Managers of Val Verde Memorial Hospital*, 437 F.2d 173 (CA5–1971).

[27] *Capili* v. *Shott*, 487 F.Supp. 710 (S.D. West Va.1978), affirmed 620 F.2d 438 (CA4–1979); *Sam's* v. *Ohio Valley General Hospital*, 413 F.2d 826 (CA4–1969); *Adler* v. *Montefiore Hospital Association*, 453 Pa. 60, 311 A.2d 634 (1973) cert. denied, 414 U.S. 1131, 94 S.Ct. 870, 38 L.Ed.2d 755 (1974); *Cobb Cty., etc.* v. *Prince*, 242 Ga. 139, 249 S.E.2d 581 (1978) also see cases cited at n.17, *supra*.

VII.

The requirements of procedural due process apply only to the deprivation of interests encompassed by the Fourteenth Amendment's protection of liberty and property. When protected interests are implicated, the right to some type of hearing is paramount. But the range of interests protected by procedural due process is not infinite.[28] The Fourteenth Amendment's protection of property is intended to secure the interests that a person has already acquired in specific benefits. For a person to have a property interest in a benefit, he clearly must have more than an abstract need or desire for it. He must have a legitimate claim of entitlement to it.[29] Relying on this principle, one court has held that a physician had no right to a due process hearing prior to the hospital denying him the right to use certain hospital facilities and equipment, finding that he had no more than a unilateral expectation to use them.[30]

The rationale behind providing a physician with the right to a hearing if he has been rejected for medical staff privileges is to give the applicant a chance to explain matters which might have lead the Board to reject him.[31] He is entitled to a hearing to clear his reputation where some stigma is being imposed on him by the state which may prevent him from taking advantage of future

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[28] *Perry* v. *Sindermanm*, 408 U.S. 593, 92 S.Ct. 2694, 33 L.Ed.2d 570 (1972).

[29] *Board of Regents* v. *Roth*, 408 U.S. 564, 92 S.Ct. 2701, 33 L.Ed.2d 548 (1972).

[30] *Adler* v. *Montefiore Hospital Ass'n of W. Pa.*, 453 Pa. 60, 311 A.2d 634 (1973).

[31] *Battle v. Jefferson Davis Mem. Hospital*, 451 F.Supp. 1015 (S.D.Miss. 1976).

employment opportunities.[32] However, where an applicant's rejection has no connexity with his qualifications but rather is based on the state's desire to continue a particular system or operational regulation, his property rights are not infringed upon and he has no right to a hearing.[33]

We conclude that Dr. Hyde was not denied a property right to which he was legally entitled. It is also relevant to the Court that Dr. Hyde's qualifications were not the basis for the denial of the privileges. The Board was merely acting in conformity with its policy to have a closed system anesthesiology department. Dr. Hyde's reputation and qualifications were not at issue and therefore the underlying rationale for holding a hearing was not present. Accordingly, we conclude that plaintiff was not entitled to such a hearing under the circumstances.

VII.

Defendant Jefferson Parish Hospital District was created by the Parish of Jefferson pursuant to Chapter 10 of Title 46 of the Louisiana Revised Statutes and, accordingly, the defendants are governed by the provisions of that chapter in operating the hospital.[34] Pursuant to those provisions "the Commission (the Board of Directors) shall appoint a medical staff. Such appointments shall be made upon the recommendations of the

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[32] *Williams* v. *Barry*, 490 F.Supp. 941 (D.C. Dist. of Col.) (1980).

[33] *Cook County College Techrs. Union Local 1600* v. *Taylor*, 432 F.Supp. 270 (N.D.Ill.1977); *Manion* v. *Kreml*, 264 N.E.2d 842 (Ill.App. 1970).

[34] La.R.S. 46:1051 et seq.

physicians who are authorized to practice in the hospital."[35] Plaintiff relies on the case of *Giles* v. *Breaux*[36] to support his argument that this provision imposes a mandatory duty on the Board of Directors to appoint physicians upon the recommendation of the medical staff.

Giles, an intermediate appellate court decision, involved an interpretation of Act No. 129 of 1950, containing the same language as the above cited provision, which was applicable to the St. Tammany Parish Hospital District. The case involved the revocation of staff privileges of a physician and the Court stated that, in its opinion, the language placed on the Commission the mandatory obligation to appoint any physician recommended for staff privileges by the medical staff.

This Court does not feel bound by *Giles* because it involved an interpretation of a different provision of law. We also find that the *Giles* court did not give a reasonable interpretation to the language contained in the provision.

The Jefferson Parish Council, by ordinance, has made the Board of Directors ultimately responsible for the administration and operation of East Jefferson Hospital.[37] The provisions of the hospital's by-laws[38] and the

---

[35] La.R.S. 46:1058.

[36] *Giles* v. *Breaux*, 160 So.2d 608 (La.App. 1 Cir. 1964).

[37] See plaintiff's exhibit 2, By-laws of East Jefferson General Hospital.

[38] Article VI, Section 1 of the East Jefferson By-laws provides upon recommendation by the Credentials Committee and the Executive Committee of the Medical Staff, the Board approves membership on the Medical Staff.

by-laws of the medical staff [39] provide for the Board making the ultimate determination with regard to the appointment of physicians to the medical staff after the Credentials and Medical Executive Committee have reviewed their qualifications and made a recommendation. We interpret La.R.S. 46:1058 to provide that the Board could not appoint a physician who has not received a favorable recommendation from the medical staff. It does not require the Board to appoint every physician receiving a favorable recommendation. Our interpretation gives the language used in the above provision its common and ordinary meaning in accordance with the rules of statutory construction.[40]

IX.

We hold that the hospital was not involved in the diagnosis or treatment of patients and was not illegally engaging in the unauthorized practice of medicine.[41]

X.

For the foregoing reasons, let judgment be entered in favor of defendants, Jefferson Parish Hospital District No. 2 and East Jefferson Hospital Board and against plaintiff, Dr. Edwin G. Hyde, dismissing plaintiff's suit at his cost.

---

[39] Article III, Section 3 of the Medical Staff By-laws provide in part: Initial appointments ... to the Medical Staff shall be made by the governing body. The governing body shall act on appointments ... only after there has been a recommendation from the medical staff as provided in the by-laws.

[40] La.R.S. 1:3 and 1:4.

[41] *Rush* v. *City of St. Petersburg*, 205 So.2d 11 (Fla.App. 1967).

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 81-3091

D. C. Docket No. CA 78-750 "F"

DR. EDWIN G. HYDE,
Plaintiff-Appellant,

v.

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 and the EAST JEFFERSON HOSPITAL BOARD,
Defendants-Appellees.

Appeal from the United States District Court
for the Eastern District of Louisiana

Before GARZA, POLITZ, and WILLIAMS,
Circuit Judges.

JUDGMENT

This cause came on to be heard on the record on appeal and was argued by counsel;

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court that the judgment of the said District Court in this cause be, and the same is hereby, reversed;

IT IS FURTHER ORDERED that defendants-appellees pay to plaintiff-appellant the costs on appeal to be taxed by the Clerk of this Court.

SEPTEMBER 20, 1982

Office-Supreme Court, U.S.
FILED
MAY 13 1983
ALEXANDER L. STEVAS,
CLERK

No. 82-1031

In the Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 AND EAST JEFFERSON HOSPITAL BOARD, PETITIONERS

v.

EDWIN G. HYDE, RESPONDENT

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

JOINT APPENDIX

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PETITION FOR CERTIORARI FILED DECEMBER 17, 1982
CERTIORARI GRANTED MARCH 7, 1983

FRANK H. EASTERBROOK
1111 EAST 60TH STREET
CHICAGO, ILLINOIS 60637

RECEIVED
MAY 20 1983
OFFICE OF THE CLERK
SUPREME COURT, U.S.

May 16, 1983

Mr. Alexander Stevas
Clerk of the Court
Supreme Court of the
United States
Washington, DC 20543

Re: Jefferson Parrish Hospital District No. 2 v. Hyde, No.82-1031

Dear Mr. Stevas:

I regret the fact that the charts at pages 39-48 of the Joint Appendix in this case are not particularly readable. The originals from which they were reproduced are even worse and the Health System Agency which prepared the originals is defunct so that we can no longer obtain clean copies. The record contains the originals which the court can consult in the event that is necessary and I also enclose with this letter our best available copies, the ones we furnished to the printer. I hope this will provide an adequate point of reference. At least, the Court can take comfort in the fact that the data one digested at pages 49-50 of the Joint Appendix and Appendix B to petitioners brief on the merit so that reference to the charts themselves should prove unnecessary.

Sincerely,

Frank Easterbrook

Frank H. Easterbrook/kp

FHE:kp
Enclosures

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NOTE: The opinion of the district court, the opinion of the court of appeals, and the judgment of the court of appeals may be found at Pet. App. 1a-48a.

RELEVANT DOCKET ENTRIES — DISTRICT COURT

Docket No. 78-0750

DATE	NR.	PROCEEDINGS
3/7/78	1	COMPLAINT — (2) summs Issg.
3/8/78	2	Pltf's Mtn for Preliminary Injunction
4/28/78	12	MEMO IN OPPOSITION to Mtn for Preliminary Injunction
6/8/79	21	PRE TRIAL CONF HLD: (MLJR 6-8-79) PT Order approved, TRIAL SET 11-15-79. ENT 6-11-79
8/31/79	31	ANSWER of Jeff. Parish Hospital District No. 2 and Jefferson Hospital Board to Complt
11/2/79	57	ORDER: (LLM 10-31-79) TRIAL CONTINUED TO BE RESET, All Cut Off Dates indefinitely extended. ENT 11-2-79
11/15/79	60	PRE TRIAL CONF HLD: (MLJR 11-15-79) PT Order previously approved; AMENDMENTS BY 5-2-80; TRIAL SET 5-15-80. ENT 11-16-79
5/15/80	74	TRIAL HLD: (LLM 5-15-80) NON JURY; Testimony heard, continued to 5-16-80. ENT 5-19-80
5/16/80	75	TRIAL HLD: (LLM 5-16-80) Defts Mtn. to Dismiss DENIED; Deft.'s Mtn. for Directed Verdict DENIED; Post Trial Briefs 6-5-80; Reply Briefs due 6-16-80 ENT 5-19-80.

DATE	NR.	PROCEEDINGS
1/23/81	79	FINDINGS OF FACT AND CONCLUSION OF LAW. (LLM) 1-23-81, ENT 1-26-81.
1/23/81	80	JUDGMENT in favor of defts Jefferson Parish Hospital District No. 2 and East Jefferson Hospital Board and against pltf, Dr. Edwin G. Hyde, DISMISSING pltfs suit at his cost. (LLM) 1-23-81, ENT 1-26-81.1
2/17/81	86	Pltf's NOTICE OF APPEAL.

RELEVANT DOCKET ENTRIES — COURT OF APPEALS

Case Number 81-3091

4/15/81	Record on Appeal No. of Vols. 4
5/12/81	Supp. Record No. of Vols. 1
7/21/81	Brief for Appellant (M)
10/20/81	Briefs for Appellees (PT) 10-27-81 (M)
1/18/82	Filing Motion to Dismiss by Appellee
1/19/82	Response filed by Appellant
2/11/82	Denied by Court
3/15/82	Case Assigned for 4-19-82 in E. Hearing Panel: RGG-HAP-JSW
4/19/82	Case Argued by Appellant, by Appellee
9/20/82	Opinion Rendered, RGG Reversed, Signed
10/12/82	Jdgt. as Mdt. Issd. to Clerk

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

DR. EDWIN G. HYDE	CIVIL ACTION
VS.	NO. 78-750
JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 AND THE EAST JEFFERSON HOSPITAL BOARD	SECTION "F"
	MAGISTRATE DIV. 5

COMPLAINT

Plaintiff, Dr. Edwin G. Hyde ("Dr. Hyde"), brings this civil action against the Jefferson Parish Hospital District No. 2 ("the District") and the East Jefferson Hospital Board ("the Board") praying for preliminary and permanent injunctive relief and alleges the following facts:

Jurisdiction and Venue

1. This Court has jurisdiction over the subject matter of Count I of this action under 28 U.S.C. §1343 in that plaintiff seeks in Count I to redress the deprivation, under color of state law, of a right secured by the Constitution of the United States.

2. This Court has jurisdiction over the subject matter of Counts II and III under 28 U.S.C. §1337 in that the causes of action alleged in these counts arise under an Act of Congress protecting trade and commerce against restraints and monopolies.

3. The pendant jurisdiction of this Court is invoked with respect to Counts IV, V and VI. Although the causes of action alleged in these counts arise under the laws of the State of Louisiana, they involve a common nucleus of operative fact upon which Counts I, II and III are based.

4. Venue for all counts is proper in the Eastern District of Louisiana.

The Parties

5. Dr. Hyde is a physician who is duly qualified to engage, and does engage, in the practice of medicine in Louisiana. Dr. Hyde specializes in anesthesiology.

6. The District is a political subdivision of the State of Louisiana created by Ordinance No. 4049 of the Parish of Jefferson, State of Louisiana, pursuant to La. R.S. 46:1051, *et seq.*, and is domiciled in the Parish of Jefferson, State of Louisiana.

7. The District owns and operates the East Jefferson General Hospital (the Hospital), the affairs of which are administered by the East Jefferson Hospital Board; created by Jefferson Parish Ordinance No. 9393, pursuant to La. R.S. 46:1053.

Underlying Facts

8. The District is a "hospital service district" created under La. R.S. 46:1051, *et seq.*, to provide hospital services for residents of Jefferson Parish, Louisiana. It owns and operates the Hospital, which is governed by the Board, the members of which are appointed by the Jefferson Parish Council. The day-to-day operation of the Hospital is administrated by an Executive Director appointed by the Board. The current Executive Director is Mr. Mose Ellis. Within the Hospital is a Department of Anesthesiology.

9. In July of 1977, Dr. Hyde submitted an application to Mr. Ellis for appointment to the Hospital's medical staff. Pursuant to procedures set forth in the Hospital's By-Laws, Dr. Hyde's application was approved by the Credentials Committee and the Executive Committee of the Hospital's medical staff and was transmitted to the Board for acceptance.

10. On October 19, 1977, Dr. Hyde was advised by Mr. Ellis that the Board had voted to not accept Dr. Hyde's

application on the basis of an "exclusive" contract between the Hospital and Roux & Associates, a professional medical corporation specializing in anesthesiology, and the fact that no openings existed in the Hospital's Department of Anesthesiology.

11. The terms of the contract between the Hospital and Roux & Associates grants to Roux & Associates the exclusive right to provide and administer all anesthetics and related services to patients in the care of the Hospital and provides for the sharing, between the Hospital and Roux and Associates, of all fees generated by the administration of anesthetics to patients referred to Roux & Associates by the Hospital.

12. Plaintiff believes, and therefore alleges, that the Hospital maintains and operates twelve (12) operating rooms and that Roux & Associates employs only three (3) physicians specializing in anesthesiology.

Count I

13. The Board's rejection of Dr. Hyde's application, done under color of state law, was arbitrary and capricious and denied to Dr. Hyde equal protection and due process of law as guaranteed by the Fourteenth Amendment to the United States Constitution.

14. The arbitrary and capricious nature of the Board's action is demonstrated by the illegality of the grounds upon which its decision was allegedly based. The exclusive contract between the Hospital and Roux & Associates, which was cited by Mr. Ellis as a reason for the rejection of Dr. Hyde's application, is illegal and invalid under Louisiana law for the following reasons:

(a) The contract's provision for the sharing of professional fees by the Hospital and Roux & Associates constitutes illegal "fee splitting" in violation of La. R.S. 37:1284.

(b) The contract calls for the exercise of professional medical discretion by the Hospital in referring patients to Roux & Associates and constitutes the unlicensed practice of medicine by the Hospital in violation of La. R.S. 37:1270.

15. The Board's second ground for rejecting Dr. Hyde's application, that there are no openings in the Hospital's Department of Anesthesiology, is unsupported by fact in that the number of anesthesiologists employed by Roux & Associates (three) is clearly inadequate to service properly the number of operating rooms maintained by the Hospital (twelve). Moreover, at least one of those three physicians is normally working at another hospital. The need for additional anesthesiologists at the Hospital was demonstrated by the approval of Dr. Hyde's application by the Credentials and Executive Committees of the Hospital's medical staff.

16. The arbitrary and capricious nature of the Board's action is further demonstrated by the fact that the Board's rejection of Dr. Hyde's application after it was approved by the Hospital's medical staff violated both La. R.S. 46:1058 and the By-Laws of the Hospital. La. R.S. 46:1058 directs the Board to make appointments to the medical staff "upon the recommendations of the physicians who are authorized to practice within the hospital." Article VI, Section 1 of the Hospital's By-Laws provides that "upon recommendation by the Credentials Committee and Executive Committee of the medical staff, the Board approves membership on the Medical Staff." Each of these provisions impose upon the Board a mandatory duty to appoint Dr. Hyde to the Hospital's medical staff.

17. Because the Board's refusal, under color of state law, to appoint Dr. Hyde to the medical staff had no rational basis, but rather was an arbitrary and capricious decision, Dr. Hyde has been denied equal protection and due process of law, as guaranteed by the Fourteenth Amendment.

Count II

18. The contract between the Hospital and Roux & Associates constitutes a tying arrangement which is illegal per se under Section 1 of the Sherman Act, 15 U.S.C. §1.

19. The Hospital has sufficient economic power with respect to the tying product, the providing of hospital surgical facilities, to appreciably restrain free competition in the market for the tied product, the provision of anesthesia services. The Hospital's economic power with respect to the tying product is demonstrated by the Hospital's unique position as the sole supplier of surgical facilities open to the public on the East Bank of Jefferson Parish, a heavily populated area.

20. The foregoing tying arrangement substantially affects interstate commerce. Such commerce includes, but is not limited to: (a) the purchase in interstate commerce by persons other than the Hospital of hospital supplies and medicines used in the practice of anesthesiology; (b) the interstate travel by physicians to Louisiana for the purpose of practicing medicine at the Hospital and other hospitals in surrounding areas; and (c) the interstate travel by patients to Louisiana for treatment at the Hospital.

Count III

21. In addition to being a per se illegal tying arrangement, the contract between the Hospital and Roux & Associates also constitutes a conspiracy in restraint of trade in violation of the provisions of Section 1 of the Sherman Act, 15 U.S.C. §1.

22. The purpose and effect of the contract is unreasonably to restrain trade in the providing of anesthesia services to the public in Jefferson Parish.

23. This restraint of trade, while occurring in intrastate commerce, substantially affects interstate commerce in the following nonexclusive particulars:

(a) Under its contract with Roux & Associates, the Hospital is granted the right to purchase and furnish all supplies and medicines used in the practice of anesthesiology at the Hospital. Such supplies and medicines are purchased in substantial quantities by the Hospital in interstate commerce. The contract between the Hospital and Roux & Associates has the effect of restraining interstate purchases of such supplies and medicines by anesthesiologists in Jefferson Parish from sources other than those used by the Hospital since such anesthesiologists are excluded from practicing at the Hospital.

(b) The contract between the Hospital and Roux & Associates restrains the interstate travel of anesthesiologists to Jefferson Parish by restricting unreasonably the professional opportunities for such physicians by prohibiting them from practicing at the Hospital.

Count IV

24. The contract between the Hospital and Roux & Associates constitutes an illegal restraint of intrastate trade in the provision of anesthesia services in violation of La. R.S. 51:122. Dr. Hyde is entitled to an injunction prohibiting this violation of state law under the provisions of La. R.S. 51:129.

Count V

25. The contract between the Hospital and Roux & Associates constitutes an illegal attempt to monopolize intrastate trade in the provision of anesthesia services in violation of La. R.S. 51:123. Dr. Hyde is entitled to an injunction prohibiting this violation of state law under La. R.S. 51:129.

Count VI

26. The Board's refusal to appoint Dr. Hyde to the Hospital's medical staff, after Dr. Hyde's application had been approved by the Credentials and Executive Committees of the medical staff, violates La. R.S. 46:1058, which imposes a mandatory duty upon the governing board of a state hospital service district to appoint physicians to the hospital medical staff upon the recommendation of the medical staff. Under Louisiana law, Dr. Hyde is entitled to an injunction prohibiting this violation of state law and requiring the Board to appoint him to the Hospital's medical staff.

Prayer for Relief

WHEREFORE, the plaintiff prays that:

(a) the action of the Board in rejecting Dr. Hyde's application to the medical staff of the Hospital be adjudged and decreed to be in violation of the Fourteenth Amendment of the United States Constitution;

(b) the exclusive contract between the Hospital and Roux & Associates be adjudged and decreed to be in violation of Section 1 of the Sherman Act;

(c) the exclusive contract between the Hospital and Roux & Associates be adjudged and decreed to be in violation of the antitrust laws of the State of Louisiana;

(d) the Board's rejection of Dr. Hyde's application be adjudged and decreed to be in violation of La. R.S. 46:1058;

(e) a preliminary and, ultimately, a permanent injunction issue requiring the District and the Board to appoint Dr. Hyde to the active medical staff of the Hospital;

(f) there be judgment ordering the defendants to pay all costs of this action, including reasonable attorneys' fees; and

(g) the Court enter such further orders and decrees as it may deem proper and just.

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John M. Landis
Of
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WITTMANN & HUTCHINSON
1000 Whitney Bank Building
New Orleans, Louisiana 70130
Telephone: 581-3200

Attorneys for Plaintiff

AFFIDAVIT

STATE OF LOUISIANA
PARISH OF ORLEANS

BEFORE ME, the undersigned authority, personally came and appeared:

DR. EDWIN G. HYDE

who, after being duly sworn, did depose and say that he is the plaintiff in the above and foregoing complaint, that he has read said complaint, and that the information contained in said complaint is true and correct to the best of his knowledge and belief.

Dr. Edwin G. Hyde

Sworn to and subscribed before
me this 7th day of March, 1978.

Notary Public

PLEASE SERVE:

Jefferson Parish Hospital District No. 2
East Bank Office Building
3300 Metairie Road
Metaire, Louisiana

East Jefferson Hospital Board
4200 Houma Boulevard
Metairie, Louisiana

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF LOUISIANA

DR. EDWIN G. HYDE	CIVIL ACTION
VS.	NO. 78-750
JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 AND THE EAST JEFFERSON HOSPITAL BOARD	SECTION "F"
	MAGISTRATE DIV. 5

ANSWER OF JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 AND THE EAST JEFFERSON HOSPITAL BOARD

NOW INTO COURT come, through undersigned counsel, JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 and the JEFFERSON HOSPITAL BOARD, and for answer to the complaint of DR. EDWIN G. HYDE with respect show that:

FIRST DEFENSE

The complaint fails to state a claim upon which relief can be granted.

SECOND DEFENSE

There is a lack of jurisdiction over the subject matter in that Counts II and III are based upon Section 1 of the Sherman Act, 15 U.S.C., Section 1. To be within the jurisdiction of the Sherman Act, the action of the defendants must adversely affect interstate commerce. The action taken by the defendants in this matter has no effect whatsoever on interstate commerce.

THIRD DEFENSE

The court has no jurisdiction over the claims asserted in Counts IV, V and VI. The pendent jurisdiction of this court was invoked as to these claims. These claims are based upon

the same set of facts as those of Counts II and III. As the court has no jurisdiction over Counts II and III, it has no pendent jurisdiction as to Counts IV, V and VI, which arise under the laws of the State of Louisiana.

FOURTH DEFENSE

In response to Count I of the complaint, the defendants answer that their action was reasonable, and not arbitrary and capricious, and therefore, not a denial of equal protection or of due process of law. Defendants further answer that their decision to have a "closed department" in anesthesiology was an informed and carefully reasoned one. The defendants' contract with Roux & Associates is reasonable in that it provides for the efficient and orderly operation of the hospital.

FIFTH DEFENSE

The complaint fails to state a claim upon which relief can be granted in that the contract between the hospital and Roux & Associates does not constitute a trying arrangement which is illegal per se. The contract has no impact on interstate commerce. Furthermore, the hospital does not have sufficient economic power with respect to the tying product, the providing of surgical facilities, to restrain free competition in the market for the tied product, the providing of anesthesia services. The hospital has no substantial control over the market for surgical facilities. The hospital is not the sole supplier of surgical facilities on the East Bank of Jefferson Parish. In addition, it is defendants' position that the market for hospital surgical facilities is not limited to the East Bank of Jefferson Parish. The proper market to consider is that of the entire Greater New Orleans area in which there are at least 24 hospitals providing surgical facilities.

SIXTH DEFENSE

The complaint fails to state a cause of action upon which relief can be granted in that it is not a conspiracy in restraint of trade. Furthermore, the contract between the hospital and Roux & Associates has no substantial effect on interstate commerce.

SEVENTH DEFENSE

Further answering, the hospital action has not violated LSA-R.S. 46:1058. This statute does not impose a mandatory duty on the Board to appoint all physicians approved by the Medical Staff. The Hospital's action was in accordance with the Bylaws and Charter of the hospital, as well as the Bylaws of the Medical Staff, which Dr. Hyde, in his application, agreed to be bound by. In fact, Dr. Hyde has waived any objection to the denial of his application by his failure to request a hearing as provided in the Medical Staff Bylaws, Article VIII, Section 1(c), which provides that, "The failure to request, in writing by certified mail, return receipt, a hearing within sixty (60) calendar days from the date on which the Administrator mails the notice of the adverse decision to the affected physician shall constitute a waiver of his right to the hearing and to an acceptance of the adverse recommendation."

EIGHTH DEFENSE

Answering the numbered allegations of the complaint, defendants admit the allegations of paragraphs 5, 6, 7, 8, 9, and 10; deny the allegations of paragraphs of 1, 2, 3, 4, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25 and 26; show that, with respect to paragraph 11, the contract between the hospital and Roux & Associates is the best evidence of the terms stated therein; deny the allegations of paragraph 12, but

admit that Roux & Associates only employed three physicians specializing in anesthesiology, and further state that the hospital only had seven operating rooms and one cystography procedure room.

WHEREFORE, defendants, JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 and the EAST JEFFERSON HOSPITAL BOARD, pray that there be judgment entered herein in its favor, dismissing the complaint of DR. EDWIN G. HYDE, together with all costs of these proceedings.

MMAHAT, GAGLIANO,
DUFFY & GIORDANO

By: _____

LUCAS J. GIORDANO,
Attorney for Jefferson
Parish Hospital District
No. 2 and the East Jefferson Hospital Board,
Suite 300, 5500 Veterans
Blvd. Metairie, LA
70003 (887-6962)

CERTIFICATE OF SERVICE

I certify that prior to the filing of these pleadings in this Court, copies thereof were mailed to all counsel of record.

Date 8/29/79

ANESTHESIOLOGY AGREEMENT

THIS AGREEMENT, made and executed in duplicate at Metairie, Louisiana as of February 12, 1971, by and between Parish of Jefferson (East Jefferson General Hospital) hereinafter referred to as "Hospital, and ROUX & ASSOCIATES (A Professional Medical Corporation), hereinafter referred to as "Roux & Associates".

WITNESSETH:

WHEREAS, the parties desire to provide a full statement of their agreement in connection with the operation of the department of anesthesia in the Hospital during the term of this contract.

THEREFORE, in consideration of the mutual covenants and agreements of this contract, it is understood and agreed by and between the parties hereto as follows:

FIRST: Roux & Associates shall designate one of its qualified anesthesiologists to serve as the professional and administrative head of the Hospital's department of anesthesia. Said anesthesiologist and any other anesthesiologists provided by Roux & Associates under this contract shall be members in good-standing of the active medical staff of the Hospital. Upon the recommendation of the Executive Committee of the medical staff and approval of the Hospital Board, which shall be bound by the recommendation of the Executive Committee of the medical staff, such status will be granted to the anesthesiologists provided by Roux & Associates. They shall have the privileges and responsibilities of active staff membership, and shall be subject to all of the medical staff bylaws, rules and regulations.

SECOND: The Hospital shall make available during the term of the contract the space designated for the department of anesthesia, and in addition, the Hospital shall make available such equipment as is required for the proper operation and conduct of the department. The Hospital shall also keep

and maintain said equipment in good order and repair. The Hospital shall furnish the department with utilities and with such ordinary housekeeping, maintenance, and other services as may be required for the proper operation and conduct of the department. Such space, equipment and services shall be mutually acceptable to both parties to this contract.

THIRD: The Hospital shall purchase all necessary supplies for the department of anesthesia and shall keep accurate records of the cost thereof.

FOURTH: All nursing personnel required for the operation of the department of anesthesia shall be employed by the Hospital, but the selection and retention of such personnel shall be subject to the approval of Roux & Associates. Salaries, benefits, and personnel policies applicable to persons employed in the department of anesthesia shall be uniform with those of other Hospital employees in similar personnel classifications.

FIFTH: Roux & Associates shall operate the department of anesthesia at the Hospital and shall designate a duly qualified physician and anesthesiologist employed by it to serve as its head who shall devote his best ability to its proper management. Roux & Associates and the physicians and anesthesiologists employed by it shall confine their practice of anesthesiology to the Hospital and shall not provide services or be associated actively, financially or otherwise with any group providing anesthesia services at any other location, except as may be authorized in writing by the Hospital. The Hospital shall restrict the use of its anesthesia department to Roux & Associates and no other persons, parties or entities shall perform such services within the Hospital for the terms of this contract.

SIXTH: Roux & Associates shall participate in the educational programs and in-service training conducted by the Hospital and shall perform such other teaching functions within the Hospital as are necessary to assure the Hospital's

compliance with requirements of accrediting bodies such as the American Medical Association and the Joint Commission on Accreditation of Hospitals.

SEVENTH: Roux & Associates shall comply with the policies, rules, and regulations of the Hospital.

EIGHTH: Roux & Associates agree to perform all anesthesia services required in the care of Hospital patients, Hospital employees, volunteers, and Hospital students. Charges for anesthesia services for the following classifications of patients may be reduced in the discretion of the Hospital and at such reduced rate shall be included in billings for the purpose of Paragraph Twelfth even though such charges may be carried for accounting purposes by the Hospital at the normal full rate of billing: 1) Patients to the extent that their bills are reduced for indigency or similar good reasons such as the pursuit of research and special studies or courtesy, 2) students of the Hospital, 3) volunteers, 4) Hospital employees injured or afflicted within the scope of their employment (to the extent to which the charge must be borne by the Hospital or the employee) and 5) Hospital employees, in accordance with Hospital personnel policies.

NINTH: Upon the receipt of written recommendations of Roux & Associates, the Hospital shall establish the amounts to be charged to patients for services rendered in the Hospital's department of anesthesia. Before these charges can be modified, the Hospital shall seek the counsel and written recommendations of Roux & Associates. The amounts to be charged patients for services rendered in the Hospital's department of anesthesia shall include the Hospital's cost of maintaining the department and, shall include as an element, the amount due Roux & Associates for professional and administrative services.

TENTH: The Hospital shall maintain a record of all services rendered to patients by the department of anesthesia.

The Hospital shall collect the charges for these services at the same time as charges owed by said patients for other services are collected.

ELEVENTH: Roux & Associates must provide the services of at least two full-time anesthesiologists within _____ days after opening the Hospital. Both shall be full qualified and acceptable to the credentials committee of the medical staff and to the Hospital Board.

TWELFTH: On or before the 15th day of each month, the Hospital shall present to Roux & Associates a statement of income pertaining to the anesthesia services rendered to in-patients and out-patients for the preceding month, together with a check representing the amount due Roux & Associates to be fixed as follows:

From the total of charges as defined in this agreement for said preceding calendar month reported by the Hospital as heretofore provided, the Hospital shall deduct three per cent (3%) from the billings as an allowance for bad debts. Of the remaining amount, fifty per cent (50%) shall be the amount due Roux & Associates which shall be paid over to it with said statement. The remainder thereof shall be retained by the Hospital for Hospital services rendered. The Hospital shall charge the patient for drugs and other anesthesia supplies separately.

THIRTEENTH: Roux & Associates will cooperate with and assist other members of the staff in preparation of clinical reports for publication and will use its best efforts to elevate the standing of the Hospital staff in the field of medical science by publication of unusual or interesting studies made in the department of anesthesia.

FOURTEENTH: Roux & Associates shall furnish physicians and anesthesiologists who shall be present in the Hospital and shall consult with and work with staff physicians in proper cases, during such hours as the Hospital shall determine to be necessary and proper. Nothing contained in this

paragraph or in this agreement shall be construed to permit assignment by Roux & Associates of any rights under this agreement, and such assignment is expressly prohibited.

FIFTEENTH: Roux & Associates may fulfill its obligation herein, during the temporary absence of staff members due to vacation, attendance at scientific meetings, illness or other approved periods of absence from the Hospital, by providing on a temporary basis qualified physicians who may not be members of the medical staff, in order to maintain a high level of service in the department of anesthesia.

SIXTEENTH: When the Hospital, upon receiving recommendations from the medical staff Executive Committee and from the department of surgery, determines that the volume of work in the Hospital has reached an average level which makes it difficult for two anesthesiologists to supply anesthesia services at a high quality level, Roux & Associates shall furnish such qualified physicians as may be necessary to adequately staff the anesthesia department.

SEVENTEENTH: This agreement shall remain in full force and effect for a term of one (1) year from and after February 14, 1971, and shall be automatically renewed for successive one (1) year terms, unless either party serves written notice upon the other of a desire to terminate the agreement at least ninety (90) days prior to such termination.

IN WITNESS WHEREOF, the parties hereto do hereby execute the foregoing agreement on this 12th day of February, 1971.

ATTEST: _____

_____

ANESTHESIOLOGY AGREEMENT

THIS AGREEMENT, made and executed in duplicate at Metairie, Lousiana as of January 10, 1976, by and between East Jefferson General Hospital, hereinafter referred to as "Hospital", and Roux & Associates (A Professional Medical Corporation), hereinafter referred to as "Roux & Associates".

WITNESSETH:

WHEREAS, the parties desire to provide a full statement of their agreement in connection with the operation of the department of anesthesia in the Hospital during the term of this contract.

THEREFORE, in consideration of the mutual covenants and agreements of this contract, it is understood and agreed by and between the parties hereto as follows:

FIRST: Roux & Associates shall designate one of its qualified anesthesiologists to serve as the professional and administrative head of the Hospital's department of anesthesia as provided for in the By-laws of the Medical Staff. Said anesthesiologist and any other anesthesiologists provided by Roux & Associates under this contract shall be members in good standing of the active medical staff of the Hospital. Upon the recommendation of the Executive Committee of the medical staff and approval of the Hospital Board, which shall be bound by the recommendations of the Executive Committee, such status will be granted to the anesthesiologists provided by Roux & Associates. They shall have the privileges and responsibilities of active staff membership, and shall be subject to all of the medical staff bylaws, rules and regulations.

SECOND: The Hospital shall make available during the term of the contract the space designated for the department of anesthesia, and in addition, the Hospital shall make available during the term of the contract such equipment as is

required for the proper operation and conduct of the department, in accordance with the needs of the medical staff under an approved budget, and the requirements of the Joint Commission on Accreditation of Hospitals, and all state and federal laws. The Hospital shall also keep and maintain said equipment in good order and repair. The Hospital shall furnish the department with utilities and with such ordinary housekeeping, maintenance, and other services as may be required for the proper operation and conduct of the department. Such space, equipment and services shall be mutually acceptable to both parties of this contract, subject to budgetary limitations.

THIRD: The Hospital shall purchase all necessary supplies for the department of anesthesia and shall keep accurate records of the cost thereof. All requests for equipment and supplies should be submitted by Roux & Associates to Administration, and at the option of Roux & Associates concurrently to the Board, and if the requests are not acted upon promptly by Administration, then Roux & Associates may request the Board to act on same.

FOURTH: All nursing personnel required for the operation of the department of anesthesia shall be employed by the Hospital, but the selection of such personnel shall be subject to the approval of Roux & Associates and the terms and conditions of their employment within the applicable hospital personnel policy shall be subject to the approval of Roux & Associates. Discharge of personnel recommended by Roux & Associates shall be subject to Hospital personnel policy. Salaries, benefits, and personnel policies applicable to persons employed in the department of anesthesia shall generally conform with those of other Hospital employees in similar personnel classifications in the New Orleans area. All matters dealing with personnel which are not handled by Administration to the satisfaction of Roux & Associates may be brought to the Board for resolution.

FIFTH: Roux & Associates and the physicians and anesthesiologists employed by it shall confine their practice of anesthesiology to the Hospital and shall not provide anesthesia services or be associated actively, financially or otherwise with any group providing anesthesia services at any other location, except as may be provided for herein. Notwithstanding the above, the Hospital agrees to teaching, research, and limited consultative activities by the anesthesiologists other than on the Hospital premises, so long as such activities do not interfere with the quality of anesthesia services in the Hospital and do not interfere with the anesthesiologists' personal availability to the Hospital's medical staff.

SIXTH: Roux & Associates shall participate in the educational programs and in-service training conducted by the Hospital and shall perform such other teaching functions within the Hospital as are necessary to assure the Hospital's compliance with requirements of accrediting bodies such as the American Medical Association and the Joint Commission on Accreditation of Hospitals.

SEVENTH: Roux & Associates shall comply with the policies, rules and regulations of the Hospital, as long as they do not violate any prevailing standards of medical practice or constitute a breach of medical ethics.

EIGHTH: Roux & Associates agree to perform all anesthesia services required in the care of Hospital patients, Hospital employees, volunteers, and Hospital students. Charges for anesthesia services for the following classifications of patients may be reduced in the discretion of the Hospital and at such reduced rate shall be included in billings for the purpose of Paragraph Eleventh even though such charges may be carried for accounting purposes by the Hospital at the normal full rate of billing: 1) students of the Hospital, 2) volunteers, 3) Hospital employees injured or afflicted within the scope of their employment (to the extent to which

the charge must be borne by the Hospital or the employee) and 4) Hospital employees, in accordance with Hospital personnel policies.

NINTH: Upon the receipt of written recommendations of Roux & Associates, the Hospital shall establish the amounts to be charged to patients for services rendered in the Hospital's department of anesthesia. Before these charges can be modified, the Hospital shall seek the counsel and written recommendations of Roux & Associates. The amounts to be charged patients for services rendered in the Hospital's department of anesthesia shall include the Hospital's cost of maintaining the department and, shall include as an element, the amount due Roux & Associates for professional and administrative services.

TENTH: The Hospital shall maintain and make available upon request of Roux & Associates a record of all services rendered to patients by the department of anesthesia. The Hospital shall collect the charges for these services at the same time as charges owed by said patients for other services are collected.

ELEVENTH: On or before the 10th day of each month, the Hospital shall present to Roux & Associates a statement of charges pertaining to the anesthesia services rendered to in-patients and out-patients for the preceding month, together with a check representing the amount due Roux & Associates to be fixed as follows:

From the total of charges as defined in this agreement for said preceding calendar month reported by the Hospital as heretofore provided, the Hospital shall deduct eight per cent (8%) from the billings as a combined allowance for bad debts, charity, and other writeoffs. Of the remaining amount, fifty per cent (50%) shall be the amount due Roux & Associates which shall be paid over to it with said statement. The

remainder thereof shall be retained by the Hospital for Hospital services rendered. The Hospital shall charge the patient for drugs and other anesthesia supplies separately.

TWELFTH: Roux & Associates will cooperate with and assist other members of the staff in preparation of clinical reports for publication and will use its best efforts to elevate the standing of the Hospital staff in the field of medical science by publication of unusual or interesting studies made in the department of anesthesia.

THIRTEENTH: Roux & Associates shall furnish physicians and anesthesiologists who shall be present in the Hospital and shall consult with and work with staff physicians in proper cases, during such hours as the Hospital shall determine to be necessary and proper. Nothing contained in this paragraph or in this agreement shall be construed to permit assignment by Roux & Associates of any rights under this agreement, and such assignment is expressly prohibited.

FOURTEENTH: Roux & Associates may fulfill its obligation herein, during the temporary absence of staff members due to vacation, attendance at scientific meetings, illness or other approved periods of absence from the Hospital, by providing on a temporary basis qualified physicians who may not be members of the medical staff, in order to maintain a high level of service in the department of anesthesia.

FIFTEENTH: When the Hospital, upon receiving recommendations from the medical staff executive committee, determines that the volume of work in the Hospital has reached an average level which makes it difficult for two anesthesiologists to supply anesthesia services at a high quality level, Roux & Associates shall furnish such qualified physicians as may be necessary to adequately staff the anesthesia department.

SIXTEENTH: This agreement shall remain in full force and effect for a term of five (5) years from and after February 14, 1976.

IN WITNESS WHEREOF, the parties hereto do hereby execute the foregoing agreement on this 10th day of January, 1976.

Roux & Associates, Inc.
(A Professional Medical
Corporation)

ATTEST:

_____ _____

Kermit L. Roux, President

_____

East Jefferson General
Hospital

By _____
Mose Ellis, Administrator

By _____
Charles J. Eagan, Jr.,
Chairman
Jefferson Parish Council

ATTACH IN LEFT A RECENT PHOTOGRAPH (AT LEAST PASSPORT SIZE)

APPLICATION FOR APPOINTMENT TO THE MEDICAL AND DENTAL STAFF EAST JEFFERSON GLENDALE HOSPITAL

Metairie, Louisiana

Date 7-14-77

Name Hyde (last) Edwin (first) C. (initial)

Office Address:
Primary #114, 4648 I-10 Service Rd., Met, LA 70001
Secondary
Telephone Exchange
Residence Address
Sex m Marital Status single No. of Dependents 5

Telephone:
Primary 888-0240
Secondary
Date of Birth 7/5/32
Telephone
Citizenship U.S.

Premedical Education: College or University UCLA/San Diego State College
Degree B.S. Date of Graduation 1957

Medical/Dental Education: Medical/Dental School Tulane Univ. School of Medicine
Degree M.D. Date of Graduation 1962

Internship: Hospital Jackson Mem. Hosp. N.W. 10 Ave. Miami, Fl. 33136
Date 1961-62 Rotating ☒ Special ☐

Rotating ☐ Special ☐

Residencies Charity Hospital, New Orleans (Anesthesiology) Date 1962–65
(hospital and Type of Residency)

(hospital and Type of Residency)

Fellowship _____

Assistantships _____

_____

Teaching Appointments _____

_____

Postgraduate Education _____
(Institution, Preceptor, Address)

_____
(Institution, Preceptor, Address)

_____
(Institution, Preceptor, Address)

Licensures Louisiana License Number 9022 Registry Number _____ Reciprocity ☐ Exam ☒
State (Date issued)

Florida License Number 11706 Registry Number _____ Reciprocity ☒ Exam ☐
California License Number 26164

Was your license to practice medicine in any jurisdiction ever been suspended or revoked? If so, give full details on separate sheet. no

Present and Previous Military Service and Dates U. S. Army Active 1953-55, Reserve 1955–63

Membership on other Hospital Staffs (past and present, state type of appointment.)
Lakeside Hospital for Women and Baptist Hospital — Louisiana (New Orleans)
North Miami General — Florida (Miami)

Have your privileges at any hospital ever been suspended, diminished, revoked, or not renewed? If so, give full detail on separate sheet. no

International Anesthesia Research Society, Jefferson Parish Medical Society

Have you ever been denied membership or a renewal thereof in a medical organization? If so, give full details on separate sheet. No

Fellowship:

American College of Surgeons ☐ American College of Physicians ☐ Date _____

Fellowship in other specialty Colleges Anesthesiologists Date 1968
(Name of College)

Eligible for certification by American Board of _____

Certified by American Board of Anesthesiologists Date 1967

Professional References and Addresses (preferably preceptors or previous medical associates.) List:

JOSEPH DUGAS, M. D., 4324 Veta. Blvd., Met, La. 70002

SAMUEL A. LEONARD, M. D., 3700 HOUMA, Met, La. 70002

AL WIEDEMANN, M. D., 4324 Veta Blvd., Met, La. 70002

On separate sheet list scientific papers, essays, and theses you have written, and scientific meetings attended during the past three years.

The undersigned applies for members on the ☒ Active ☐ Courtesy medical/dental staff of East Jefferson General Hospital and for privilege of practice as indicated below:

☐ Family Practice _____

☒ Surgery (Includes general surgery, ophthalmology, orthopedic surgery, neurosurgery, urology, anesthesiology, cardiovascular and thoracic surgery, and dentistry) List specialties:

ANESTHESIOLOGY

☐ Obstetrics and Gynecology _____

☐ Pediatrics _____

☐ Otolaryngology _____

☐ Psychiatry _____

☐ Medicine _____

☐ Other _____

In making application for appointment to the medical/dental staff of this hospital I agree to follow the laws and by such rules and regulations as it may from time to time enact. Moreover, I specifically pledge that I will not receive from or pay to another physician, either directly or indirectly, any part of a fee received for professional services, and I fully understand that any significant misstatement in or omission from this application constitute cause for summary dismissal from the staff.

/s/ EDWIN G. HYDE

OFFICIAL USE ONLY

Above application was reviewed by the Credentials Committee with the following recommendations:

Appointment to the ☐ Honorary ☐ Active ☐ Courtesy ☐ Courtesy Newborn ☐ Consulting

Division of the Medical Staff with Privileges in _____

With Privileges limited to _____

Appointment to be deferred _____ Appointment not recommended _____

Signed _____ M.D. _____

Date _____ _____

EXECUTIVE COMMITTEE

Approved by the Executive

Date _____ /s/ _____
(Secretary of Executive Committee)

GOVERNING BOARD

Appointed by the Governing Board of East Jefferson General Hospital

Date _____ _____
Secretary of Governing Board

HONORS, AWARDS, ETC.

Diplomate — American Board of Anesthesiologists — 1967

Fellow — American College of Anesthesiologists — 1969

MEETINGS ATTENDED

American Society of Anesthesiologists — 1972, 1973, 1974, 1975, 1976

American Medical Association — 1972, 1973, 1974, 1975, 1976

International Anesthesia Research Society — 1972, 1973, 1974, 1975, 1976

Post Graduate Seminar in Anesthesiology — 1972, 1973, 1974, 1975, 1976

Southern Society of Anesthesiologists — 1972, 1973, 1974, 1975, 1976

EDWIN G. HYDE, M. D. (continued)

PAPERS PRESENTED

Uses and Abuses of Vasopressors
Xth Congress of Mexican Anesthesiologists — 1963

Misuse of Adjunctive Drugs During Anesthesia
A. M. A. (Anesthesia Section) — 1964

Influence on Surgery and Anesthesia by the Status of the Patient A. M. A. (Anesthesia Section) — 1965

Anesthetic Techniques for Research Animals Used in Organ Transplantation Southern Society of Anesthesia — 1965

Influence of Prior Drug Therapy on the Patient's Anesthetic Course
Southern Society of Anesthesia — 1968

EXHIBITS PRESENTED

Uses and Abuses of Vasopressors
A. M. A. — 1963
American Society of Anesthesiologists — 1963

Adverse Effects of Drugs Used in Surgery and Anesthesia
A. M. A. — 1964

Status of the Patient; Influence During Surgery and Anesthesia A. M. A. — 1965

Adverse Effects of Local Anesthetics A. M. A. — 1966

CONTRIBUTOR TO THE FOLLOWING BOOKS

Current Concepts of Anesthesia — Volume II

Current Concepts of Anesthesia — Volume III

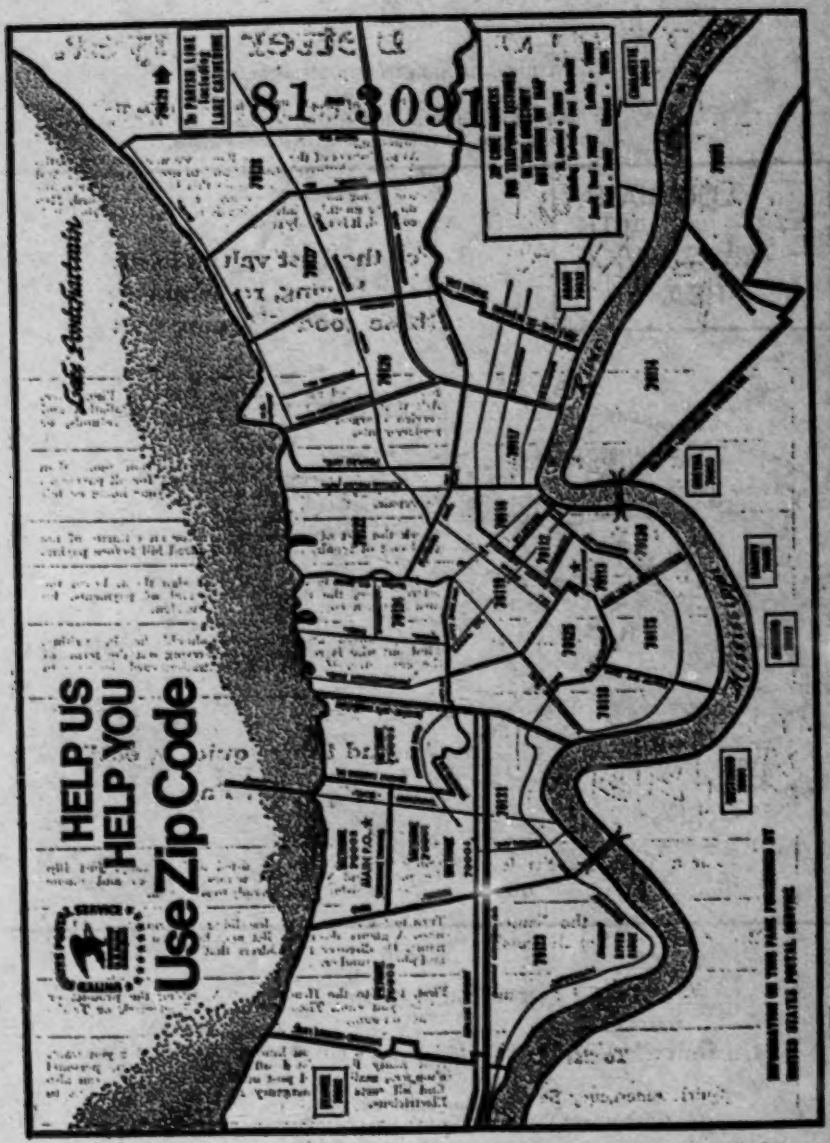
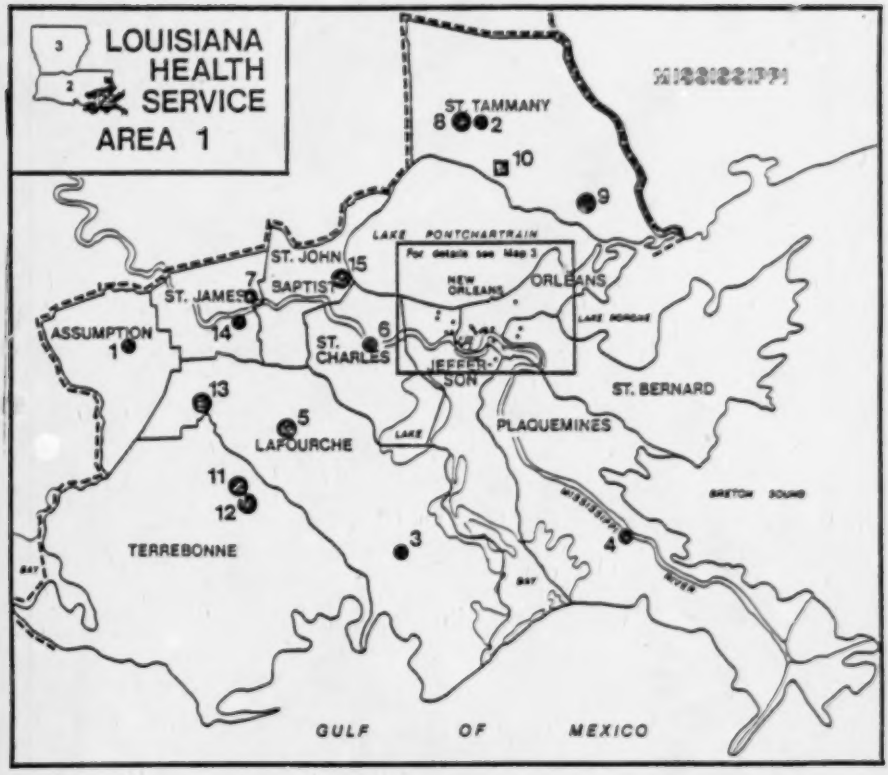


EXHIBIT D-4

MAP 2
HOSPITALS
1979
LOUISIANA HEALTH SERVICE AREA 1

Assumption, Lafourche, Plaquemines, St. Charles,
St. James, St. John, St. Tammany, and Terrebonne Parishes.



LEGEND

■ SPECIALTY HOSPITAL

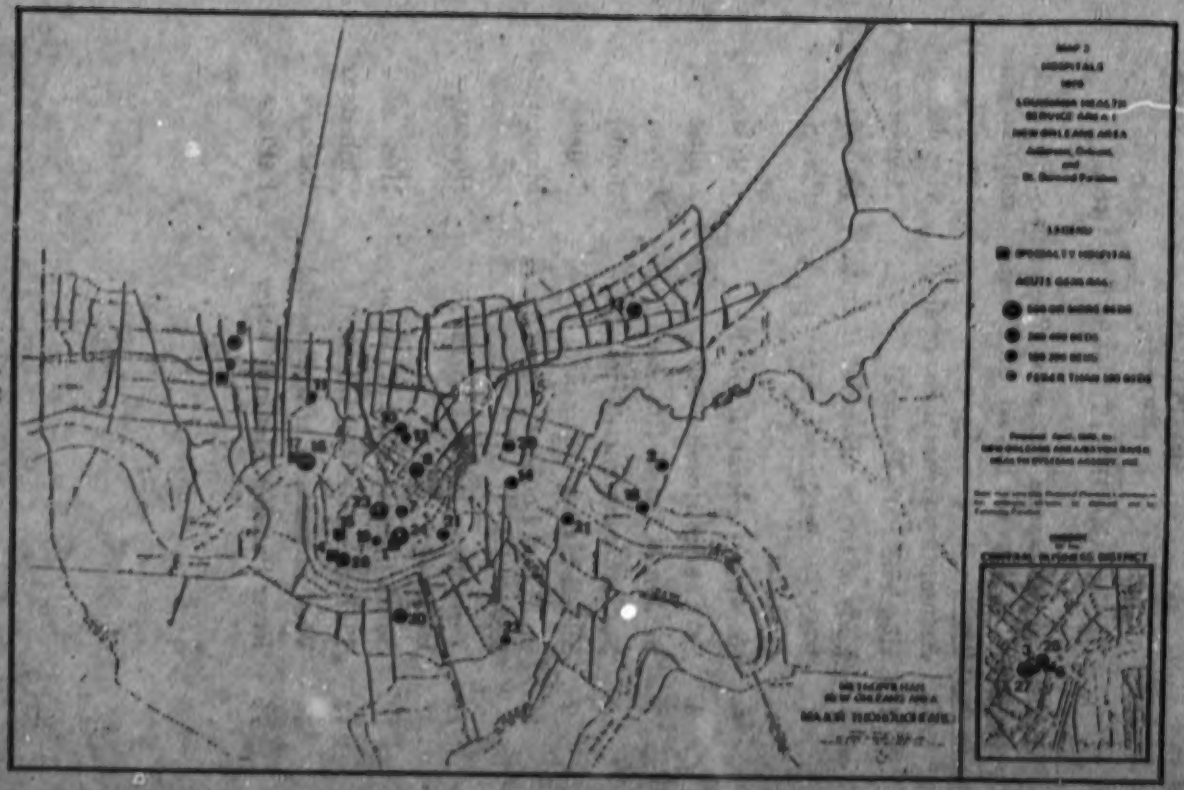
● ACUTE GENERAL 100-299 BEDS

● ACUTE GENERAL FEWER THAN 100 BEDS

prepared April 1979
NEW ORLEANS AREA/BAYOU-RIVER HEALTH SYSTEMS AGENCY, INC.

4.89

EXHIBIT D-5



MAP 2

HOSPITALS
1979

LOUISIANA HEALTH SERVICE AREA 1

Parishes of Assumption, Lafourche, Plaquemines, St. Charles, St. James, St. John the Baptist, St. Tammany, and Terrebonne

Number	Hospital	Location
1	Assumption General Hospital	Napoleonville
2	Highland Park Hospital	Covington
3	Lady of the Sea General Hospital	Galliano
4	Plaquemines Parish General Hospital	Port Sulphur
5	St. Anne General Hospital	Raceland
6	St. Charles Hospital	Luling
7	St. James Parish Hospital	Lutcher
8	St. Tammany Parish Hospital	Covington
9	Slidell Memorial Hospital	Slidell
10	Southeast Louisiana State Hospital	Mandeville
11	Terrebonne Parish General Hospital	Houma
12	South Central Medical Center	Houma
13	Thibodaux General Hospital	Thibodaux
14	West St. James Parish Hospital	Vacherie
15	River Parishes Medical Center	LaPlace

MAP 3
HOSPITALS
1979

LOUISIANA HEALTH SERVICE AREA 1

Parishes of Jefferson, Orleans and St. Bernard

Number	Hospital	Location
1	Coliseum House	New Orleans
2	Chalmette General Hospital	Chalmette
3	Charity Hospital of Louisiana at New Orleans	New Orleans
4	Children's Hospital	New Orleans
5	East Jefferson General Hospital	Metairie
6	Eye and Ear Institute of Louisiana	New Orleans
7	Flint-Goodridge Hospital	New Orleans
8	Hotel Dieu Hospital	New Orleans
9	Lakeside Hospital for Women	Metairie
10	Mercy Hospital	New Orleans
11	Metairie Hospital	Metairie
12	Pendleton Memorial Methodist Hospital	New Orleans
13	Montelepre Memorial Hospital	New Orleans
14	F. Edward Hebert Hospital	Algiers
15	New Orleans Mental Health Institute	New Orleans
16	Ochsner Foundation Hospital	Jefferson
17	River Oaks Hospital	Jefferson
18	St. Bernard General Hospital	Chalmette
19	St. Charles General Hospital	New Orleans
20	St. Claude General Hospital	New Orleans
21	JoEllen Smith Memorial Hospital	Algiers
22	South Jefferson General Hospital	Gretna
23	Southern Baptist Hospital	New Orleans
24	Touro Infirmary	New Orleans
25	Tulane Medical Center	New Orleans
26	U. S. Public Health Service Hospital	New Orleans
27	Veterans Administration Hospital	New Orleans
28	West Jefferson General Hospital	Marrero

PATIENT ORIGIN BY ZIP CODE
SELECTED HOSPITALS - NEW ORLEANS SMSA

NOVEMBER 1, 1976 - APRIL 30, 1977

PATIENT ORIGIN BY ZIP CODE
SELECTED HOSPITALS - NEW ORLEANS SMSA

May 1, 1976 - October 31, 1976

ZIP CODE	CHARITY HOSPITAL	CHILDREN'S HOSPITAL	CHILDREN HOUSE	DE PAUL HOSPITAL	EAST JEFFERSON GENERAL	FLINT-GOODRIDGE	HOTEL DIEU	JO ELLEN SMITH MEMORIAL	LAKEVIEW HOSPITAL	MERCY HOSPITAL	METAIRIE MEMORIAL	METROPOLIT.	NORTHSHORE MEMORIAL	OCHSNER FOUNDATION	RIVER OAKS	ST. HOPKINS GENERAL	ST. CLOUDE GENERAL	ST. TAMMANY GENERAL	SARA MAYO	SLIDELL MEMORIAL	SOUTH JEFFERSON GENERAL	SOUTHERN BAPTIST	TOURO INFIRMARY	WEST JEFFERSON GENERAL	TOTAL ADMISSIONS
70001	44	28	9	16	633	4	109	0	329	227	97	29	98	225	3	3	3	2	9	0	--	193	159	17	[illegible]
70002	19	10	7	0	890	1	143	10	314	164	43	37	85	175	7	1	5	0	0	--	1	291	230	13	2,429
70003	244	34	9	19	1192	19	163	0	483	194	97	23	63	263	2	3	5	1	11	--	1	305	273	24	[illegible]
70004	19	19	7	6	462	--	194	--	133	223	89	29	62	150	2	2	--	5	7	1	2	359	229	17	[illegible]
70032	45	7	7	6	19	2	153	4	23	86	2	141	21	17	1	49	69	--	0	--	--	143	57	1	806
70043	95	13	7	0	58	--	246	9	86	184	9	739	32	36	--	152	111	1	14	--	--	277	113	11	2,107
70053	299	63	22	21	30	6	197	726	67	80	6	32	28	139	1	3	0	1	21	0	258	353	179	1619	4,037
70058	215	26	9	29	14	3	25	248	25	15	3	18	2	19	--	1	1	1	18	1	69	93	46	934	1,710
70062	345	49	9	22	1169	29	133	7	969	137	102	63	99	185	2	1	13	6	30	0	6	378	191	27	[illegible]
70072	447	16	0	9	19	9	35	261	29	24	4	19	8	93	1	--	2	--	23	--	154	189	96	2505	3,816
70094	479	28	13	11	93	16	28	93	21	44	17	14	16	129	--	1	--	--	24	--	63	132	92	1221	1,673
70112	257	3	1	3	3	27	71	--	6	8	2	9	5	6	--	--	3	1	13	--	3	36	107	13	676
70115	245	19	--	3	3	166	45	6	3	15	1	4	3	9	--	--	1	--	113	--	--	19	136	3	1,337
70116	947	27	23	27	32	116	116	1039	19	53	3	27	15	95	2	1	6	1	45	--	72	239	208	224	4,292
70118	1248	30	11	14	24	223	126	6	30	92	11	28	7	214	2	3	7	1	165	--	3	499	1315	19	4,196
70119	819	13	4	5	25	98	199	8	11	67	4	24	19	39	--	3	24	--	83	--	3	99	283	6	1,364
70117	2993	31	2	23	46	245	155	19	23	238	17	225	55	68	--	32	303	1	251	--	1	227	541	29	4,989
70118	883	31	7	18	63	141	181	6	27	139	21	29	14	199	1	3	3	1	93	6	--	414	688	23	3,849
70119	1236	34	3	17	193	122	483	5	31	694	18	190	147	93	3	6	24	--	519	3	1	339	435	18	5,994
70125	84	6	3	9	397	5	39	18	77	89	41	1	21	189	3	6	9	--	3	--	--	114	85	7	[illegible]
70122	881	25	17	17	93	129	492	7	96	383	22	387	89	186	1	3	29	--	382	3	--	389	475	8	3,515
70123	149	25	8	3	447	9	91	3	133	99	29	98	28	216	--	--	3	3	3	--	1	239	139	26	1,799
70124	47	12	7	11	193	--	238	3	86	236	24	46	35	109	2	1	1	3	8	--	--	389	754	7	1,829
70125	814	25	3	10	21	159	97	1	18	52	5	14	6	68	1	3	1	1	383	--	3	248	335	5	1,966
70126	1924	25	7	16	56	269	197	8	36	313	19	895	19	53	--	7	29	3	168	3	1	199	389	26	3,600
70127	64	6	19	9	45	32	137	3	46	98	2	611	28	87	1	5	24	--	38	3	--	187	98	3	1,577
70128	33	1	1	4	3	6	19	--	7	14	3	142	4	6	1	--	6	--	8	--	--	23	33	3	346
70129	89	14	3	1	6	8	33	1	3	29	1	291	15	13	--	8	7	--	8	28	--	39	63	9	681
70130	852	9	--	14	38	79	299	3	7	44	3	7	14	63	--	--	6	--	399	--	1	154	394	33	3,938
SUBTOTAL	18,661	619	199	363	5722	1834	6393	3974	3799	3935	831	4869	985	3986	63	330	974	54	3638	69	646	6681	7837	3432	76,866
70039*	55	6	2	2	28	1	31	--	12	11	2	13	1	29	--	--	--	1039	2	2	--	43	25	2	1,724
70058**	213	23	7	9	28	3	68	9	19	34	5	327	7	69	1	4	2	65	2	2319	--	219	66	9	3,274
SUBTOTAL	18,929	649	208	373	5778	1838	6492	3974	3816	4000	838	4209	993	4084	63	334	977	1058	1834	3291	646	6923	7928	3453	79,864
ALL OTHER LA.	4335	347	54	193	933	33	814	438	653	323	34	398	93	2288	33	322	515	3039	61	535	339	3432	1856	2191	19,719
OUT OF STATE	39	28	6	31	186	38	263	33	28	93	3	118	39	1384	31	3	6	38	6	186	0	1895	--	93	3,963
OUT OF COUNTRY	--	--	--	0	4	--	2	--	--	--	--	3	93	329	1	1	--	--	3	--	3	--	--	--	852
BAD ZIP CODE ENTRIES	536	--	--	--	--	--	--	--	--	3	--	--	--	--	--	--	--	--	--	--	--	983	--	--	1,519
GRAND TOTAL	23,871	1014	268	595	6811	2101	7562	4184	3741	4377	879	5121	1110	6880	87	539	1850	3556	1889	3993	988	9836	9181	5545	99,955

* Carlstrom
** Slidell

SOURCE: Data supplied by participating hospitals

PREPARED BY: New Orleans Area/Bayou-River Health Systems Agency, Inc.

NOVEMBER 1, 1977 - APRIL 30, 1978

ZIP	CHARITY	COLLEGIUM HOUSE	DEPAUL	EYE, EAR, NOSE & THROAT	FLEMING-GOODRICH	HOTEL DIEU	JO ELLEN SMITH	LAKESIDE	MERCY	METAIRIE HOSPITAL	METROLEPY	MONTELEPRE MEMORIAL	OCHSNER FOUNDATION	RIVER OAKS	ST. BERNARD GENERAL	ST. CHARLES GENERAL	ST. CLAUDE GENERAL	ST. TAMMANY GENERAL	SAINT MARY	SOUTH JEFFERSON	SLIDELL MEMORIAL	SOUTHERN BAPTIST	TOURO INFIRMARY	WEST JEFFERSON	TOTAL ADMISSIONS
70001	93	--	18	53	2	171	6	256	110	59	46	53	260	5	--	91	0	1	13	--	1	264	184	14	1062
70002	57	6	11	34	2	114	5	333	127	27	33	42	222	2	1	89	--	1	15	1	--	203	183	17	1329
70003	367	6	17	42	12	119	14	483	181	72	32	25	310	6	1	57	6	1	16	1	--	285	190	21	245
70005	29	1	12	63	--	131	3	155	230	58	22	29	177	1	--	84	--	--	4	--	--	290	234	8	1982
70032	28	5	4	33	--	136	1	16	62	4	150	12	32	1	39	46	62	--	8	--	3	84	69	4	741
70043	61	14	10	42	5	220	9	57	163	--	739	62	61	3	141	91	62	1	9	--	1	144	187	16	1936
70053	393	9	23	43	9	4	974	57	63	2	30	26	142	1	--	66	8	3	21	169	1	169	198	1545	3762
70058	252	2	9	10	3	172	258	19	21	1	9	3	60	3	--	21	3	1	6	72	--	57	48	894	1923
70063	457	3	16	41	23	1	6	669	152	88	39	53	288	2	1	55	11	4	21	--	1	159	33	27	2150
70072	574	14	14	15	7	15	294	--	27	3	15	9	127	--	--	29	4	1	16	199	--	71	69	2544	9019
70094	525	4	5	17	23	68	121	74	9	11	14	10	196	--	1	36	--	--	7	66	3	78	54	1704	2999
70112	603	--	19	14	19	90	1	--	33	--	6	7	17	--	4	31	39	--	13	--	2	32	105	3	795
70113	1081	1	2	12	196	42	1	4	33	--	18	--	12	5	--	33	17	--	31	--	--	20	179	3	1675
70114	1060	5	27	93	57	86	1791	4	56	2	17	5	93	--	2	72	21	2	9	95	--	163	187	198	4186
70115	1378	11	16	109	324	160	6	27	78	--	57	10	145	--	2	252	19	1	84	--	--	494	946	8	4127
70116	939	6	9	42	66	195	6	6	48	1	279	10	41	--	1	59	70	1	39	1	--	49	196	7	2019
70117	2218	7	19	84	287	360	6	25	189	6	33	29	37	4	31	143	1039	1	85	1	--	161	519	11	5315
70118	993	13	25	67	128	195	4	40	105	6	133	12	224	1	--	144	24	--	75	1	--	330	599	12	3130
70119	1546	4	21	103	139	315	3	36	345	11	13	98	105	1	5	143	88	--	70	--	--	272	421	21	3180
70121	186	6	3	22	3	61	1	62	49	23	422	11	221	--	2	29	2	--	--	--	--	153	65	11	1343
70122	787	21	17	88	123	470	7	40	392	7	13	47	106	1	3	145	121	--	34	--	1	303	492	10	3220
70123	171	6	19	24	7	84	1	201	190	20	53	12	256	3	1	69	4	3	9	1	--	139	134	13	1436
70124	59	9	15	12	1	232	4	70	404	9	15	49	139	2	1	100	1	2	13	--	--	305	262	10	1776
70125	968	5	11	42	194	124	2	15	92	2	993	3	103	4	--	99	21	1	38	2	1	196	427	5	3288
70126	1864	9	8	41	119	212	15	36	180	3	987	27	89	2	2	78	487	--	33	--	1	121	315	5	3622
70127	112	--	11	33	11	106	3	39	122	--	151	29	38	--	--	22	23	--	13	1	3	97	116	4	956
70128	24	--	4	2	1	17	1	9	25	--	323	2	9	--	--	5	18	--	--	--	--	19	17	2	865
70129	150	--	2	6	5	10	1	11	24	--	8	12	19	--	2	12	9	--	1	--	8	17	25	2	333
70130	932	3	5	94	150	173	3	9	39	2	--	12	43	--	1	70	11	--	39	--	--	144	328	6	2067
SUBTOTAL	16792	368	363	1273	1832	4223	3445	3953	3575	434	4523	699	3660	44	338	2138	7069	23	798	543	25	4949	6560	7341	68084
70433*	44	1	1	6	--	57	3	23	8	2	19	1	69	1	--	13	--	1389	1	--	4	30	--	3	1633
70458**	219	3	3	33	1	49	7	24	40	2	694	6	122	1	1	82	--	21	4	--	2559	111	--	18	3799
SUBTOTAL	17845	372	367	1312	1833	4289	3454	2980	3624	438	5037	496	3851	46	339	2203	7088	1233	803	543	2588	4985	6560	7360	73535
ALL OTHER LA.	6891	2434	124	298	37	930	630	522	269	22	826 1600	72	2287	24	154	436	117	1387	269	97	340	640	954	1390	12,987 20000
OUT OF STATE	98	20	22	151	9	287	34	24	43	6	171	19	1396	19	6	38	2	30	19	8	275	167	160	111	2914
OUT OF COUNTRY	--	--	--	12	--	54	--	--	--	--	4	184	287	--	--	--	--	--	--	2	--	--	1	0	513
ZIP CODE UNKNOWN	492	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	3705	305	--	3981
GRAND TOTAL	25,486	2,826	503	1,761	1,879	5,480	3,988	3,446	3,937	496	6633 5,997	931	7,819	89	499	2,711	2,187	2,619	1,093	846	3,403	8,497	7,680	8,779	99,000 103,300

* Covington, La.
** Slidell, LA.

SOURCE: Data supplied by participating hospitals.

PREPARED BY: New Orleans Area/Bayou River Health Systems Agency, Inc.

PATIENT ORIGIN BY ZIP CODE
SELECTED HOSPITALS - NEW ORLEANS SMSA
MAY 1, 1977 - OCTOBER 31, 1977

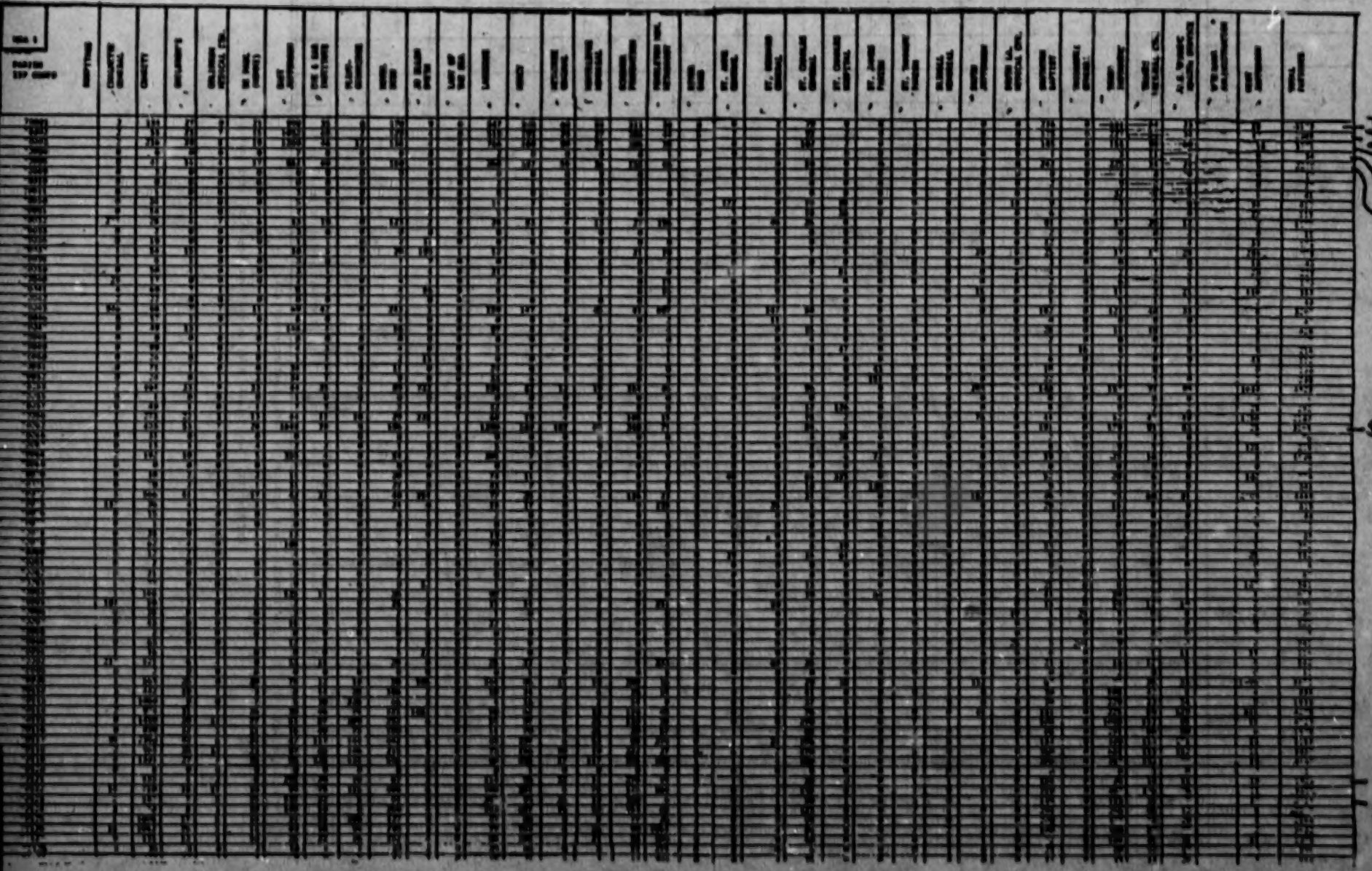
ZIP CODE	CHARITY HOSPITAL	CHILDREN'S HOSPITAL	CHILDREN HOUSE	DE PAUL HOSPITAL	EAST JEFFERSON GENERAL	EVE, EAR, NOSE & THROAT HOSPITAL	FLINT-GOODRIDGE	HOTEL DIEU	JO ELLEN SMITH MEMORIAL	LAKEVIEW HOSPITAL	MERCY HOSPITAL	METAIRIE GENERAL	METROPOLITAN HOSPITAL	NORTHLAKE HOSPITAL	OCHSNER FOUNDATION	RIVER OAKS	ST. BERNARD GENERAL	ST. CHARLES GENERAL	ST. CLAIRE GENERAL	ST. TAMMANY GENERAL	SOUTH JEFFERSON	TOURO INFIRMARY	WEST JEFFERSON GENERAL	WEST JEFFERSON GENERAL	TOTAL ADMISSIONS
70001	66	30	7	35		55	5	344	6	611	269	37	61	76	765	9	0	93	3	1	0	1	1	670	167	14	3,347
70002	26	31	3	25		63	0	167	10	397	69	30	63	31	717	7	0	76	3	2	6	0	0	747	193	11	3,396
70003	264	47	6	48		62	22	375	15	895	84	63	93	95	398	5	6	80	18	1	9	0	3	323	185	22	3,453
70005	31	30	7	19		33	1	5	5	965	243	64	30	73	15	2	11	65	6	2	31	0	1	299	291	6	3,799
70032	27	6	3	6		39	4	100	4	36	91	6	102	10	22	0	41	65	34	3	35	0	0	95	51	6	749
70043	42	28	0	11		5	0	72	2	78	137	7	634	33	67	2	344	60	72	1	23	0	0	213	121	12	1,915
70053	652	23	76	24		34	13	96	211	69	60	5	39	30	137	2	2	69	6	0	29	1	388	586	136	1,470	3,873
70056	259	12	2	14		9	3	72	191	75	15	3	9	5	51	0	8	17	8	2	6	9	81	84	39	889	1,491
70062	300	37	3	12		11	34	31	34	812	243	99	35	31	712	3	0	79	7	4	19	2	2	319	167	19	2,349
70032	197	35	2	15		22	11	76	193	58	27	6	12	12	84	1	1	19	5	0	12	2	197	131	62	1,101	2,940
70094	671	12	2	11		2	30	64	113	67	35	5	8	3	131	0	0	26	6	2	24	0	24	182	81	1,569	3,716
70112	673	3	2	0		21	28	92	0	3	19	1	6	3	9	0	0	11	24	0	3	0	0	79	65	3	737
70113	1,116	11	1	2		23	234	11	2	1	28	1	3	2	12	1	1	26	11	0	21	0	0	28	71	0	1,673
70114	1,098	28	13	12		28	122	209	1,332	31	42	2	28	2	122	1	1	42	2	0	12	0	24	129	284	117	4,823
70115	1,363	18	18	19		28	227	178	2	33	100	9	26	13	137	2	2	249	28	1	67	6	0	631	1,220	14	4,175
70116	903	5	1	9		53	93	171	1	21	95	2	23	7	23	2	0	68	63	1	73	0	0	96	269	6	1,943
70117	2,051	22	0	24		21	219	283	1	26	263	12	289	21	61	0	26	183	290	1	67	0	0	291	334	21	5,979
70118	912	24	20	24		28	178	178	6	29	116	11	21	14	227	2	0	140	17	1	67	0	1	467	699	9	3,132
70119	1,695	25	8	23		24	158	511	6	29	199	13	176	65	178	0	0	136	195	1	83	0	2	355	683	17	4,383
70125	109	5	3	6		18	13	36	1	10	28	23	13	10	151	1	0	31	1	0	7	0	0	130	69	3	930
70122	729	23	12	23		29	122	111	6	23	437	30	490	25	117	2	5	137	283	0	31	0	0	666	663	7	3,554
70123	136	12	3	6		12	6	35	3	221	90	33	6	10	199	3	0	48	0	0	9	0	0	297	173	10	1,573
70124	63	11	0	15		13	1	253	3	93	200	10	31	25	191	0	0	130	7	4	6	0	1	291	223	7	1,879
70125	973	9	31	7		24	201	123	3	19	30	0	15	6	86	2	3	93	30	1	30	0	0	223	201	6	2,213
70126	1,335	18	7	15		46	135	306	6	33	102	1	990	28	73	1	6	69	229	0	73	1	0	178	254	1	3,729
70127	335	15	2	6		16	16	138	6	69	150	1	665	28	41	2	7	68	32	0	23	0	0	173	139	5	1,783
70128	36	6	0	1		3	2	23	1	0	26	0	158	3	21	1	1	1	7	0	1	0	0	22	12	1	323
70129	121	7	2	1		6	12	20	1	53	20	1	57	2	17	0	4	13	11	1	3	10	0	29	21	0	421
70130	1,018	9	1	13		48	73	151	6	26	28	2	6	5	24	1	0	26	28	0	30	0	0	128	799	0	2,830
SUBTOTAL	16,933	553	384	384		1,034	2,222	4,950	2,783	3,396	3,730	489	4,964	532	3,380	66	440	2,265	1,681	77	634	32	613	6,677	6,923	6,527	99,997
70433*	32	4	1	1		2	0	21	3	32	13	0	0	0	21	0		0	1	220	2	2	1	24	13	2	393
70458**	130	21	1	3		21	1	28	2	20	48	2	170	12	2	0	2	29	2	28	1	1,211	0	163	12	0	1,336
SUBTOTAL	17,095	578	388	388		1,078	2,223	4,999	2,788	3,348	3,791	491	5,134	544	3,403	66	442	2,294	1,684	305	637	33	614	6,864	6,948	6,529	101,726
ALL OTHER LA.	1,960	297	31	140		200	133	1,200	681	839	496	91	1,221	214	1,693	18	163	333	135	1,290	128	903	743	1,338	900	1,936	31,715
OUT OF STATE	89	31	5	33		137	0	230	39	35	36	3	185	22	1,160	25	5	31	3	24	0	290	6	329	284	260	3,637
OUT OF COUNTRY	0	0	0	0		0	0	0	0	0	0	0	0	0	200	1	0	0	0	0	1	1	0	0	0	0	439
NO ZIP CODE	201	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	3	0	0	111	223	0	3,130
GRAND TOTAL	19,329	908	520	561		1,335	2,356	6,229	3,528	3,997	4,363	586	6,540	780	6,363	110	610	2,629	1,822	3,619	769	3,827	373	9,191	8,355	8,365	139,995

*Covington
**Slidell

SOURCE: Data supplied by participating hospitals

PREPARED BY: New Orleans Area Health Systems Agency, Inc.

LOUISIANA HEALTH SERVICE AREA 1
PATIENT ORIGIN BY ZIP CODE REPORT
MAY 1, 1979 - OCTOBER 31, 1979



PATIENT [illegible]

Nov 1, 1978 - October 31, 1978

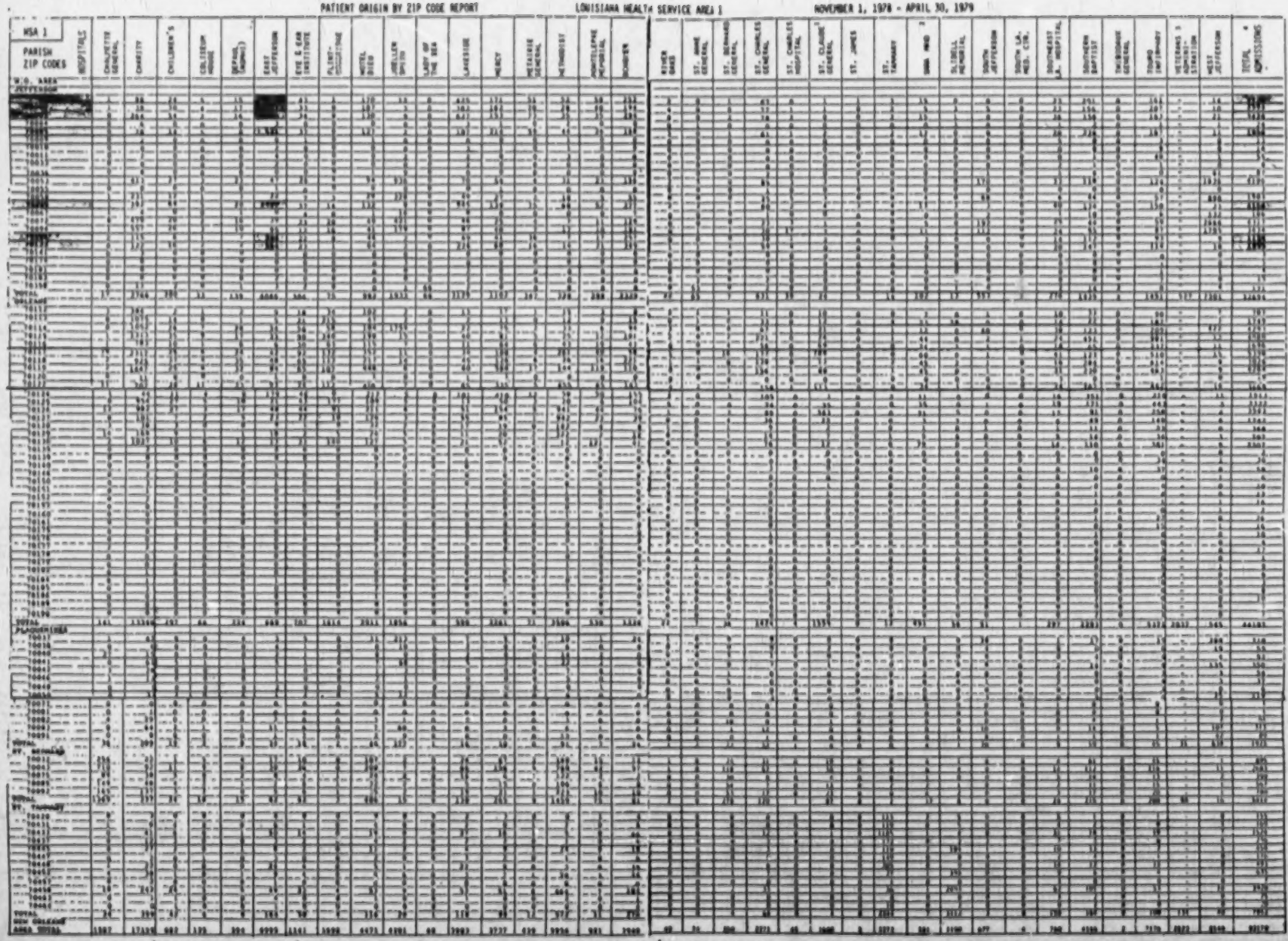
ZIP CODE	CHARITY HOSPITAL	COLMAN HOUSE	ETH & ENT INSTITUTE OF NEW ORLEANS	FLINT-GOODRIDGE HOSPITAL	GAUSE, ELLIS HOSPITAL	JO ELLEN SMITH MEMORIAL HOSPITAL	LAKESIDE HOSPITAL	MERCY HOSPITAL	METHODIST HOSPITAL	MEMORIAL HOSPITAL	NEW ORLEANS MENTAL HEALTH INSTITUTE	NORTH FOUNDATION HOSPITAL	RIVER OAKS HOSPITAL	ST. BERNARD GENERAL HOSPITAL	ST. CHARLES GENERAL HOSPITAL	ST. CHARLES HOSPITAL	ST. CLAIRE HOSPITAL	ST. THOMAS GENERAL HOSPITAL	SARA MAYO HOSPITAL	ILLINOIS MEMORIAL HOSPITAL	SOUTH JEFFERSON GENERAL HOSPITAL	SOUTHERN BAPTIST HOSPITAL, INC.	TERRY INFIRMARY	WEST JEFFERSON GENERAL HOSPITAL	TOTAL ADMISSIONS
[illegible]	106	1	71	0	103	10	375	194	67	40	58	11	230	2	1	99	1	3	1	16	0	0	102	176	24	1613
[illegible]	54	0	54	3	125	0	246	164	20	52	40	14	222	0	1	90	0	4	2	11	1	2	154	262	7	9284
[illegible]	305	9	59	21	117	0	470	174	74	35	35	12	522	4	0	92	3	3	1	20	1	[illegible]	195	163	24	2158
[illegible]	46	7	46	0	140	7	140	220	34	20	26	12	184	3	0	72	0	6	7	14	0	1	233	214	11	1484
1534	26	5	28	0	100	1	31	62	1	167	10	2	21	1	43	30	0	48	0	6	3	0	46	55	0	727
1943	98	10	52	0	211	8	88	181	0	843	60	12	94	1	144	48	0	52	0	6	2	1	103	139	14	2330
1953	284	0	48	10	93	745	68	98	2	31	18	30	140	3	0	55	7	7	2	22	1	190	147	137	1728	4142
1954	223	3	15	5	27	295	35	23	2	8	4	6	67	1	0	14	0	6	0	11	1	63	44	41	1005	1909
[illegible]	536	4	69	10	157	15	792	160	91	61	54	32	312	4	0	90	2	7	0	21	6	2	196	288	27	3819
1972	635	7	29	15	38	175	31	27	2	29	3	16	129	2	2	22	4	28	0	11	1	136	44	58	2747	4404
1994	453	3	24	31	54	177	87	22	5	10	4	11	196	0	0	29	17	10	0	14	5	87	98	87	1782	3366
1132	461	2	21	20	101	0	3	23	1	10	3	5	10	1	3	16	0	19	0	12	0	8	23	89	1	829
1133	1153	3	29	262	35	1	1	23	4	6	1	5	9	1	0	30	0	35	0	36	18	0	29	168	3	1833
1134	1251	9	45	103	184	1627	36	74	4	29	13	32	132	2	8	69	2	16	0	28	0	50	133	204	488	4827
1135	1354	9	97	370	140	0	10	96	0	25	23	25	196	1	1	205	0	32	0	84	0	0	421	1013	10	4174
1136	909	2	50	27	140	3	10	74	1	52	15	5	29	1	1	79	0	84	2	51	0	0	96	211	5	1831
1137	2066	6	113	158	384	13	27	209	3	281	40	14	43	2	23	194	0	1386	0	127	1	2	133	534	20	6257
1138	893	9	87	166	280	5	33	134	0	23	12	27	223	1	1	150	0	22	1	70	1	0	92	646	10	2599
1139	1338	3	120	128	491	7	45	364	14	119	128	11	103	0	3	144	0	146	0	72	2	0	260	305	23	4453
1140	168	0	16	11	47	11	78	55	24	8	15	6	243	0	1	45	2	4	2	9	0	0	105	95	0	970
1122	738	13	112	139	469	5	67	377	10	394	83	26	137	3	0	172	0	189	2	60	1	0	263	307	7	3747
1124	144	1	66	2	69	4	180	98	28	13	17	11	370	6	2	75	0	1	2	16	3	1	148	168	29	1813
1124	48	8	67	0	226	3	80	398	108	67	95	10	126	4	0	146	1	5	0	13	0	0	261	281	10	1781
1129	1048	7	60	186	116	5	20	62	2	25	2	15	76	1	0	104	0	26	0	46	0	0	14	454	3	2614
1130	1674	2	45	123	185	10	48	162	2	990	46	22	91	2	5	62	2	109	1	45	2	0	105	278	6	3839
1127	96	6	26	19	184	2	60	88	1	867	32	14	96	1	4	57	0	32	1	9	3	0	6	115	6	1710
1128	25	0	3	2	64	2	16	24	0	195	1	1	5	0	0	10	0	8	0	4	0	0	9	25	1	387
1129	166	2	9	5	32	0	4	21	0	266	7	4	11	0	2	14	0	20	0	15	3	0	22	35	2	731
1130	1088	30	32	367	162	4	5	54	0	13	66	11	54	0	5	79	0	27	2	103	1	3	100	466	5	2397
TOTAL	17048	146	1603	1986	4279	3749	3176	3825	380	6888	926	410	3751	53	264	2340	99	2941	32	946	56	388	3862	7206	7986	72941
1939	31	2	8	0	16	0	17	17	2	7	1	0	71	1	0	6	0	0	1255	0	2	0	30	24	1	1501
1940	263	7	28	0	64	15	68	67	4	866	7	5	123	0	2	68	0	6	42	5	2660	0	78	58	11	4027
TOTAL	294	9	36	0	82	15	85	84	6	873	8	5	194	1	2	74	0	6	1297	5	2662	0	114	79	16	5527
[illegible]	5340	65	378	30	701	1151	653	1027	77	1401	80	119	2654	23	101	696	897	110	1611	189	631	72	843	784	1278	18[illegible]
[illegible]	98	3	176	7	206	36	20	76	5	170	10	10	1328	10	6	61	9	1	29	30	294	6	163	149	111	2883
[illegible]	6	0	14	4	11	0	0	0	0	1	0	2	382	0	1	0	0	0	0	0	0	0	0	2	0	419
[illegible]	1160	0	0	1	0	0	0	1	0	0	83	0	260	0	0	0	0	0	0	26	4	0	2976	772	16	4781
GRAND TOTAL	24526	201	2007	2043	5360	4375	3850	4340	427	8488	1107	546	8533	91	436	3067	1005	3066	3964	1166	3861	641	8879	8302	9408	100297

*Covington, LA
**Slidell, LA
***Does not include October data.

SOURCE: Data supplied by participating hospitals.

PREPARED BY: New Orleans Area Bayou-River Health Systems Agency, Inc.

PATIENT ORIGIN BY ZIP CODE REPORT — LOUISIANA HEALTH SERVICE AREA 1 — NOVEMBER 1, 1978 - APRIL 30, 1979



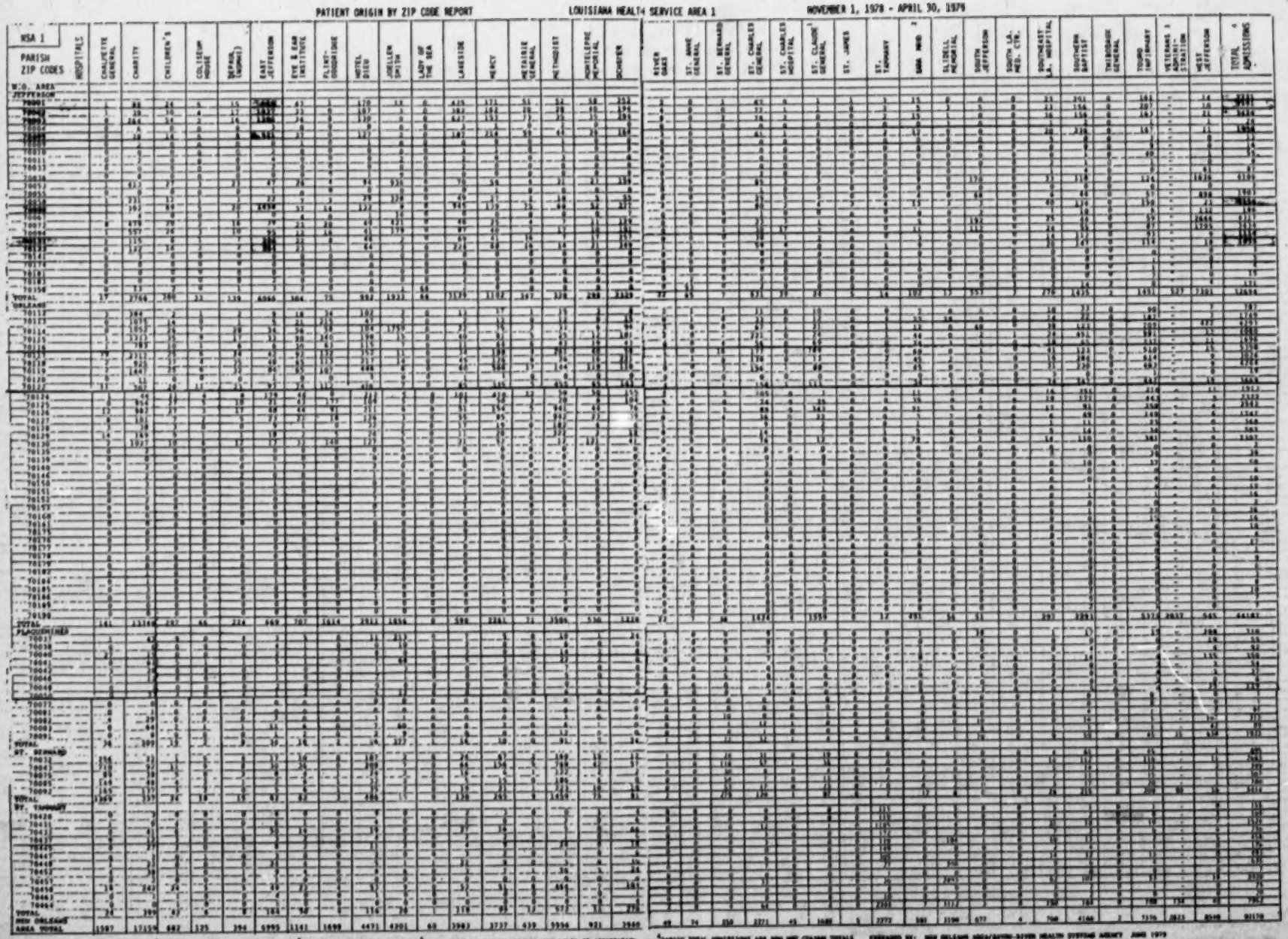
LOUISIANA HEALTH SERVICE AREA 1
PATIENT ORIGIN BY ZIP CODE REPORT
NOVEMBER 1, 1978 - APRIL 30, 1979

HSA 1 PARISH ZIP CODES / HOSPITALS	CHALMETTE GENERAL	CHARITY	CHILDREN'S	COLISEUM HOUSE	DEPAUL (NOVA)	EAST JEFFERSON	EYE & EAR INSTITUTE	FLINT-GOODRIDGE	HOTEL DIEU	JO ELLEN SMITH	LADY OF THE SEA	LAKESIDE	MERCY	METAIRIE GENERAL	METHODIST	NOTTLEPHE MEMORIAL	OCHSNER	RIVER OAKS	ST. ANNE GENERAL	ST. BERNARD GENERAL	ST. CHARLES GENERAL	ST. CHARLES HOSPITAL	ST. CLAUDE[1] GENERAL	ST. JAMES	ST. TAMMANY	SARA MAYO [2]	ELIZELL MEMORIAL	SOUTH JEFFERSON	SOUTH LA. MED. CTR.	SOUTHEAST LA. HOSPITAL	SOUTHERN BAPTIST	TRISTOPHER GENERAL	TOURO INFIRMARY	VETERANS ADMINI-STRATION [3]	WEST JEFFERSON [4]	TOTAL ADMISSIONS
ALGIERS AREA																																				
70114	0	1	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	2
70131	0	19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	14	0	0	0	33
70170	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	14	0	0	0	18
70172	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
70178	0	12	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	14
70181	0	12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	13
70183	0	11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	12
70186	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
TOTAL	0	145	2	0	0	1	0	0	2	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0	1	0	0	0	28	0	0	0	183
LAFOURCHE																																				
70301	0	149	11	0	1	21	0	0	13	0	0	12	0	0	0	0	0	1	41	0	7	3	0	0	0	0	0	110	72	13	169	24	0	17	0	655
70338	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
70345	0	16	0	0	0	0	0	0	0	0	432	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	448
70354	0	4	0	0	0	0	0	0	0	0	786	0	0	0	0	0	0	0	271	0	3	0	0	0	0	0	0	1	1	14	36	0	0	0	0	836
70355	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	154	0	2	0	0	0	0	0	0	0	0	1	11	10	0	0	0	179
70357	0	17	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	62	0	1	0	0	0	0	0	0	0	0	0	14	0	0	0	0	94
70372	0	8	0	0	0	0	0	0	0	0	225	0	0	0	0	0	0	0	166	0	1	0	0	0	0	0	0	14	0	1	14	0	0	0	0	421
70373	0	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	9
70374	0	17	0	0	0	0	0	0	0	0	65	0	0	0	0	0	0	0	34	0	2	1	0	0	0	0	0	0	0	0	7	0	0	0	0	126
70375	0	8	0	0	0	0	0	0	0	0	43	0	0	0	0	0	0	0	537	0	0	0	0	0	0	0	0	1	0	0	29	6	0	0	0	646
70394	0	12	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	32	0	0	0	0	0	0	0	0	0	0	0	7	0	0	0	0	51
TOTAL	0	243	11	0	1	21	0	0	13	0	1551	12	0	0	0	0	0	1	1332	0	16	4	0	0	0	0	0	126	73	29	268	40	0	17	0	3435
ST. CHARLES																																				
70030	0	11	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	192	0	15	95	0	0	0	0	0	0	0	0	20	0	0	0	0	414
70031	0	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	2	55	0	0	0	0	0	0	0	0	2	0	0	0	0	61
70038	0	10	0	0	0	0	0	0	0	0	17	0	0	0	0	0	0	0	15	0	4	38	0	0	0	0	0	0	0	0	6	0	0	0	0	73
70047	0	36	1	0	0	136	1	0	16	0	0	0	40	12	0	0	0	0	6	0	13	122	0	0	0	0	0	0	0	0	32	0	0	0	0	377
70049	0	19	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	134	0	0	0	0	0	0	0	0	0	0	0	0	0	155
70066	0	28	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	21	0	0	0	0	0	0	0	0	0	0	0	0	0	23
70070	0	11	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	24	0	0	0	0	0	0	0	0	0	0	0	0	0	26
70078	0	32	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	36	0	0	535	0	0	0	0	0	0	0	0	0	0	0	0	0	571
70079	0	64	0	0	0	102	0	0	10	0	0	0	48	0	0	0	0	0	0	0	1	4	0	0	0	0	0	0	0	0	0	0	0	0	0	69
70068	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	8
70083	0	44	0	0	0	21	0	0	0	0	0	0	15	0	0	0	0	0	29	0	10	66	0	0	0	0	0	0	0	0	7	0	0	0	0	133
70088	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	2
TOTAL	0	400	24	1	1	260	1	0	26	0	17	0	103	12	0	0	0	1	366	0	128	1125	0	0	0	0	0	0	0	0	107	0	0	0	0	2421
ST. JAMES																																				
70083	0	11	0	0	0	15	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	115	0	1	0	0	0	0	0	0	0	0	116
70071	0	11	0	0	0	22	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	130	0	0	0	0	0	0	0	0	0	0	130
70084	0	5	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
70085	0	12	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
70087	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
70090	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
70073	0	53	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
70764	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	1
70782	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	0	92	0	0	0	41	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	245	0	1	0	0	0	0	0	0	0	0	290
ST. JOHN																																				
70043	0	107	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
70051	0	85	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
70068	0	139	0	0	0	245	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
70069	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
70076	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
70084	0	140	0	0	0	115	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	0	332	2	0	0	360	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
LEASIDE/NCNOE																																				
70343	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	4
70344	0	11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3
70345	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
70346	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
70356	0	11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
70360	1	140	11	0	1	11	11	0	31	0	0	1	15	14	0	0	0	0	44	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
70377	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
70395	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
70396	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	1	176	11	0	1	11	11	0	31	0	0	1	15	14	0	0	0	0	53	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
S. P. AREA TOTAL	1	1357	59	1	2	694	12	0	78	0	1568	13	118	26	0	0	0	2	2052	0	151	1129	0	0	245	0	1	126	73	29	375	40	0	17	0	7506
GRAND TOTAL	1617	27038	951	116	488	8211	1486	1745	1351	1343	1709	40315	4083	476	4328	954	16296	93	25nd	367	2696	492	1698	348	2816	699	1745	784	1281	1377	2829	2099	8132	2167	97588	125778

[1] Excludes March and April totals
[2] Hospital closed March 1979
[3] Does not provide data by zip code level of aggregation
[4] Parish total admissions are row not column totals

SOURCE: Data Provided by PARTICIPATING HOSPITALS
PREPARED BY: New Orleans Area/Bayou - River Health Systems Agency
June 1979

PATIENT ORIGIN BY ZIP CODE REPORT — LOUISIANA HEALTH SERVICE AREA 1 — NOVEMBER 1, 1978 - APRIL 30, 1979



[1] EXCLUDES MARCH AND APRIL TOTALS [2] HOSPITAL CLOSED MARCH 1979 [3] DOES NOT PROVIDE DATA BY ZIP CODE LEVEL OF AGGREGATION [4] PARISH TOTAL ADMISSIONS ARE NOW NOT CLAIMS TOTALS PREPARED BY: NEW ORLEANS AREA/BAYOU-RIVER HEALTH SYSTEMS AGENCY JUNE 1979

LOUISIANA HEALTH SERVICE AREA 1
PATIENT ORIGIN BY ZIP CODE REPORT
NOVEMBER 1, 1978 - APRIL 30, 1979

HSA 1 PARISH ZIP CODES	HOSPITALS	CHALMETTE GENERAL	CHARITY	CHILDREN'S	COLISEUM HOUSE	DEPAUL (NONMI)	EAST JEFFERSON	EYE & EAR INSTITUTE	FLINT-GOODRIDGE	HOTEL DIEU	JO ELLEN SMITH	LADY OF THE SEA	LAKESIDE	MERCY	METAIRIE GENERAL	METHODIST	MONTELEPRE MEMORIAL	OCHSNER	RIVER OAKS	ST. ANNE GENERAL	ST. BERNARD GENERAL	ST. CHARLES GENERAL	ST. CHARLES HOSPITAL	ST. CLAUDE[1] GENERAL	ST. JAMES	ST. TAMMANY [2]	SARA MAYO	SLIDELL MEMORIAL	SOUTH JEFFERSON	SOUTH LA. MED. CTR.	SOUTHEAST LA. HOSPITAL	SOUTHERN BAPTIST	THIBODAUX GENERAL	TOURO INFIRMARY	VETERANS [3] ADMINI-STRATION	WEST JEFFERSON [4]	TOTAL ADMISSIONS
ASSUMPTION RIVER AREA																																					
ASSUMPTION																																					
70339	0	3	0	0	0	0	0	0	0	2	2	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	36	1	-	0	51
70341	0	39	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	0	41
70376	0	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	0	181
70377	0	22	1	0	0	0	0	0	1	2	0	0	1	2	0	0	0	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	118	0	-	0	131
70390	0	92	1	0	0	0	3	4	1	2	0	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	20	1	-	0	49
70391	0	22	0	0	0	0	0	0	0	4	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	11	1	-	0	39
70393	0	13	0	0	0	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	0	9
70394	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	17	1	4	440	12	22	8	562
TOTAL	0	195	2	0	0	0	4	5	1	8	4	0	4	2	0	2	0	0	0	4	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
LAFOURCHE																																					
70301	0	148	11	1	4	5	21	5	0	11	0	2	12	1	0	0	0	1	0	41	0	7	3	0	0	0	3	0	0	318	22	13	1691	24	-	12	2354
70338	0	8	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	0	1
70345	0	18	2	1	1	0	4	6	0	7	1	469	7	6	0	0	0	0	0	271	0	2	0	0	0	0	0	0	0	17	0	1	56	3	-	1	888
70354	0	4	0	1	1	0	0	2	0	4	0	286	1	4	0	0	0	0	0	154	0	2	0	0	0	0	0	0	0	9	0	1	15	10	-	1	508
70355	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	44	0	1	0	0	0	0	1	0	0	1	0	0	1	0	-	0	49
70357	0	12	2	0	0	0	2	1	0	0	1	229	0	4	0	0	0	0	0	144	0	0	0	0	0	0	0	0	0	14	0	0	14	9	-	1	475
70371	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	23	0	-	0	27
70372	0	1	1	0	0	0	0	0	0	0	1	66	0	0	0	0	0	0	0	54	0	2	1	0	0	0	0	0	0	1	0	0	6	1	-	1	284
70373	0	13	1	1	0	0	0	0	0	0	0	43	0	0	0	0	0	0	0	557	0	4	1	0	0	0	0	0	0	1	0	0	29	6	-	0	1589
70374	0	0	0	0	0	0	0	1	0	1	0	1	0	0	0	0	0	0	0	77	0	1	0	0	0	0	0	0	0	1	0	0	125	9	-	0	1855
70394	0	77	1	1	2	1	1	1	0	1	1	0	0	0	0	0	0	0	0	285	0	0	0	0	0	0	0	0	0	26	0	0	0	0	-	0	6838
TOTAL	0	287	23	11	13	[redacted]	19	1	32	12	1097	27	10	1	7	2	0	1	0	2084	0	26	7	0	0	0	4	0	0	208	45	31	1944	95	61	43	6838
ST. CHARLES																																					
70030	0	31	2	1	0	3	2	0	2	4	0	1	0	0	0	0	0	0	0	192	0	15	95	0	0	0	0	0	0	20	5	7	7	7	-	29	414
70031	0	19	0	0	0	4	2	0	0	3	0	1	1	0	23	0	0	0	0	7	0	2	55	0	0	0	0	0	0	0	0	1	2	2	-	42	161
70038	0	56	0	0	0	2	0	0	1	12	0	17	2	0	0	0	0	0	0	15	0	4	36	0	0	0	0	0	0	0	0	1	6	2	-	30	229
70047	0	54	5	0	0	130	5	4	16	0	0	11	0	0	0	0	0	0	0	1	0	11	11	0	0	0	0	0	0	0	0	1	20	9	17	3	377
70057	0	39	3	0	0	8	2	0	2	1	0	0	0	0	0	0	0	0	0	1	0	7	134	0	0	0	0	0	0	0	0	0	2	1	-	23	738
70066	0	29	1	0	0	1	4	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	21	0	0	0	0	0	0	1	1	1	31	4	12	0	59
70078	1	21	7	0	0	15	4	0	17	22	1	36	0	0	0	0	0	0	0	34	0	1	526	0	0	0	0	0	0	2	0	0	3	0	-	0	718
70079	0	32	0	0	0	15	1	0	0	0	0	19	0	0	0	0	0	0	0	0	0	1	4	0	0	0	0	0	0	2	2	2	45	0	10	0	83
70080	0	64	1	0	2	107	4	0	10	0	0	46	0	0	0	0	0	0	0	0	0	1	1	0	0	0	0	0	0	1	1	1	1	0	2	23	311
70083	0	9	0	0	0	2	0	0	1	0	0	0	0	0	0	0	0	0	0	29	0	0	66	0	0	0	0	0	0	0	0	0	2	0	2	0	109
70087	0	44	0	0	0	21	0	0	1	0	0	15	0	0	0	0	0	0	0	0	0	1	3	0	0	0	0	0	0	0	0	0	2	0	0	0	94
70088	0	4	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	4
TOTAL	2	400	25	1	5	[redacted]	23	5	35	45	1	227	31	5	31	2	1	1	0	366	0	128	975	2	0	2	2	2	2	24	21	131	14	31	45	225	3855
ST. JAMES																																					
70082	0	32	0	0	1	15	1	0	4	1	0	11	1	0	1	0	0	0	0	0	0	0	0	0	115	0	1	0	0	0	0	12	1	1	-	1	726
70071	0	71	1	0	2	22	2	0	14	0	0	10	0	0	0	0	0	0	0	0	0	0	0	0	138	0	0	0	0	1	0	12	1	4	-	2	287
70084	0	58	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	0	0	1	0	0	28	3	-	0	93
70085	0	72	2	0	0	4	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	0	0	154	11	-	0	283
70090	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	0	0
70093	0	51	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	31	0	0	0	0	0	0	0	0	0	-	0	84
70723	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	62	0	0	0	0	0	0	0	0	0	-	0	101
70763	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	0	0
70764	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	0	0
TOTAL	0	284	3	0	3	[redacted]	3	2	20	1	0	21	1	0	1	0	0	0	0	0	0	0	0	0	332	0	3	0	0	2	0	12	3	5	-	3	1334
ST. JOHN																																					
70049	0	107	2	0	0	3	2	0	1	2	1	7	0	0	1	0	0	0	0	0	0	0	0	42	0	0	0	0	0	0	0	1	10	0	-	4	191
70051	0	88	2	0	0	20	1	0	0	0	0	15	0	0	1	0	0	0	0	0	0	0	2	0	34	0	0	0	0	0	0	0	0	0	-	2	158
70068	0	135	0	0	0	245	1	0	44	0	0	171	10	0	0	0	0	0	0	0	0	1	2	0	71	0	0	0	0	0	0	1	63	0	-	2	636
70068	0	11	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	-	0	14
70079	0	11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	0	11
70076	0	51	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	0	51
70084	1	125	6	0	3	115	4	4	43	0	0	65	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	18	0	-	0	1780
TOTAL	1	524	10	0	3	[redacted]	12	4	100	2	1	251	14	0	2	0	0	0	0	0	0	1	6	0	171	0	0	0	0	1	0	14	119	0	45	51	14	3780
TERREBONNE																																					
70343	0	4	2	0	1	0	1	0	1	0	1	1	0	0	0	0	0	0	0	4	0	0	0	0	0	0	0	0	0	21	1	1	1	2	-	0	54
70344	0	11	2	0	1	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	80	1	1	1	2	-	2	117
70351	0	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	15	0	0	0	0	-	0	19
70353	0	8	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	13	0	0	1	0	-	0	36
70356	0	33	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	38	0	0	1	0	-	0	153
70358	0	16	0	0	0	2	1	0	0	0	1	2	0	0	0	0	0	0	0	14	0	0	0	0	0	0	0	0	0	52	0	0	2	0	-	0	72
70360	1	246	14	0	0	13	12	1	24	0	0	14	14	0	1	0	0	0	0	68	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	0	1292
70372	0	6	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	0	7
70375	0	8	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	0	8
70382	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	-	0	0
TOTAL	1	335	21	0	1	[redacted]	14	1	27	0	2	18	14	0	2	0	0	0	0	93	0	0	0	0	0	0	0	0	0	219	2	2	5	4	-	2	2045
E. A. AREA TOTAL	4	1862	96	13	44	[redacted]	78	13	294	79	1106	499	116	12	44	10	0	1	0	3452	0	238	831	0	1180	0	12	0	0	1127	78	378	2959	247	245	227	102975
HSA 1 TOTAL	1561	13116	772	142	448	[redacted]	1215	1715	4728	4288	1124	2592	3013	451	6630	931	1850	95	2531	351	2489	876	169	1124	2775	605	3197	683	1141	1124	6541	2952	7418	3156	3863	153	8588
OUT-OF-STATE	17	1976	153	7	39	267	198	15	554	87	28	265	116	12	177	25	2432	20	26	1	135	4	0	28	561	28	441	7	55	228	364	138	11	166	275	133	3516
OUT OF STATE	6	72	20	1	14	130	177	3	208	44	15	34	87	12	181	7	1138	19	7	1	52	11	0	9	21	0	41	0	0	0	0	0	5	0	0	0	564
OUT OF COUNTY	0	0	0	0	0	0	11	0	4	0	0	4	1	0	1	0	286	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	306
ZIP CODE UNKNOWN	3	864	0	0	0	14	0	14	0	0	0	0	0	0	0	0	228	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2845	0	296	0	4233
GRAND TOTAL	1617	27028	951	156	488	[redacted]	1505	1745	5185	4420	1289	4415	3216	475	6853	973	4734	115	2564	357	2626	891	1698	1144	3356	633	3745	704	1302	1177	6889	3099	8113	3432	9188	115758

[1] Excludes March and April totals
[2] Hospital closed March 1979
[3] Does not provide data by zip code level of aggregation
[4] Parish total admissions are row not column totals

SOURCE: Data Provided by PARTICIPATING HOSPITALS
PREPARED BY: New Orleans Area/Bayou - River Health Systems Agency
June 1979

TABLE A

HOSPITAL ADMISSIONS FROM EAST BANK JEFFERSON PARISH ZIP CODES

Time Period	Admissions to All Area Hospitals	Admissions to East Jefferson Hospital	Percentage Admitted To East Jefferson
5/1/76-10/31/76	16,134	4,821	29.9%
11/1/76-4/30/77	18,195	4,571	25.1%
5/1/77-10/31/77	No Data	No Data	No Data
11/1/77-4/30/78	No Data	No Data	No Data
5/1/78-10/31/78	No Data	No Data	No Data
11/1/78-4/30/79	17,841	5,849	32.8%
5/1/79-10/31/79	20,646	6,260	30.3%
TOTAL	72,816	21,501	29.5%

NOTES

1. All data was obtained from Defendants' Exhibit 7.
2. The East Bank Jefferson Parish zip codes for which data was used are 70001, 70002, 70003, 70004, 70005, 70062, 70121 and 70123.
3. Percentages are rounded to the nearest tenth.

TABLE B

ADMISSIONS TO EAST JEFFERSON GENERAL HOSPITAL

Time Period	Total Admissions to East Jefferson	Admissions To East Jefferson From East Bank Jefferson Parish Zip Codes	Percentage From East Bank Jefferson Parish Zip Codes
5/1/76-10/31/76	6,812	4,821	70.8%
11/1/76-4/30/77	6,466	4,571	70.7%
5/1/77-10/31/77	No Data	No Data	No Data
11/1/77-4/30/78	No Data	No Data	No Data
5/1/78-10/31/78	No Data	No Data	No Data
11/1/78-4/30/79	8,211	5,849	71.2%
5/1/79-10/31/79	9,025	6,260	69.4%
TOTAL	30,514	21,501	70.5%

NOTES

1. All data was obtained from Defendants' Exhibit 7.
2. The East Bank Jefferson Parish zip codes for which data was used are 70001, 70002, 70003, 70004, 70005, 70062, 70121 and 70123.
3. Percentages are rounded to the nearest tenth.

EAST JEFFERSON GENERAL HOSPITAL
ANESTHESIA PROFIT AND LOSS ANALYSIS

	1978	1977	1976
Gross Revenue	$1,632,016	$1,315,828	$1,187,759
Deductions From Revenue:			
1978 - 6.0%	97,920		
1977 - 8.4%		110,529	
1976 - 10.3%			122,339
Net Revenues	1,534,096	1,205,299	1,065,420
Professional Fees	667,172	529,882	474,532
Other Expenses	601,610	489,447	437,289
Total Expenses	1,268,782	1,019,329	911,821
Direct Profit or (Loss)	265,314	185,970	153,599
Indirect Cost:			
1978 @ 13.5% of Direct Cost	172,170		
1977 @ 17.0% of Direct Cost		173,286	
1976 @ 17.0% of Direct Cost			155,010
Profit or (Loss) after Indirect Cost	93,144	12,684	(1,411)
Profit or (Loss) as Percent of Gross Revenue	5.7%	1.0%	(.1%)

JULY, 1977

CURRICULUM VITAE — JOHN ADRIANI, M. D.

BORN:	BRIDGEPORT, CONNECTICUT, DECEMBER 2, 1907
MARRIED:	IRENE MILLER
CHILDREN:	ONE SON, JOHN NICHOLAS, BORN 1943 (ELECTRICAL ENGINEER)
GRANDCHILDREN:	THREE — JOHN III, MICHAEL JAMES, LISA ANN
GRAMMAR SCHOOL:	SHERIDAN — BRIDGEPORT, CONNECTICUT
HIGH SCHOOL:	CENTRAL — 1921-23-24-26 BRIDGEPORT, CONNECTICUT 1926 WINNER — FAIRCHILD PRIZE IN CHEMISTRY

COLLEGE AND PROFESSIONAL TRAINING:

A.B. — COLUMBIA COLLEGE, COLUMBIA UNIVERSITY, 1930

M. D. — COLLEGE OF PHYSICIANS AND SURGEONS, COLUMBIA UNIVERSITY, 1934

STRAIGHT SURGICAL INTERNSHIP (WITH A. M. WRIGHT, PROFESSOR OF SURGERY, NEW YORK UNIVERSITY) — FRENCH HOSPITAL, NEW YORK CITY, 1934-36 (HOUSE SURGEON LAST SIX MONTHS)

RESIDENT IN ANESTHESIOLOGY — BELLEVUE HOSPITAL (WITH E. A. ROVENSTINE), NEW YORK CITY, 1936–37

TEACHING APPOINTMENTS:

1. FELLOW, DEPARTMENT OF SURGERY (ANESTHESIA) — NEW YORK UNIVERSITY COLLEGE OF MEDICINE, 1937-38.
2. FELLOW, DEPARTMENT OF PHYSIOLOGY (WITH HOMER W. SMITH) — NEW YORK UNIVERSITY COLLEGE OF MEDICINE, 1938-39.
3. INSTRUCTOR, DEPARTMENT OF SURGERY (ANESTHESIA AND PHYSIOLOGY) — NEW YORK UNIVERSITY COLLEGE OF MEDICINE, 1939-41.
4. CLINICAL PROFESSOR OF SURGERY, CHAIRMAN OF ANESTHESIOLOGY SECTION, 1941–77; AND PROFESSOR OF PHARMACOLOGY, 1954 TO DATE — LOUISIANA STATE UNIVERSITY MEDICAL SCHOOL. (APPOINTED ASSISTANT CLINICAL PROFESSOR OF SURGERY AT LSU, 1941.)
5. PROFESSOR, GENERAL ANESTHESIA, AND HEAD OF THE DEPARTMENT — LOYOLA SCHOOL OF DENTISTRY, 1947-71. (APPOINTED ASSISTANT PROFESSOR, 1943. DENTAL SCHOOL CLOSED IN 1971.)
6. CLINICAL PROFESSOR OF SURGERY, CHAIRMAN OF ANESTHESIOLOGY SECTION — TULANE UNIVERSITY SCHOOL OF MEDICINE, 1942 - JANUARY, 1976. EMERITUS, JANUARY 1, 1976. (APPOINTED ASSISTANT CLINICAL PROFESSOR, 1941.)
7. CLINICAL PROFESSOR OF ORAL SURGERY (ANESTHESIOLOGY) — LSU SCHOOL OF DENTISTRY, 1971 TO DATE.

8. PROFESSOR OF ANESTHESIOLOGY, LSU SCHOOL OF MEDICINE — 1976. (ANESTHESIA SECTION SEPARATED FROM DEPARTMENT OF SURGERY, JANUARY 1, 1976.)
9. DIRECTOR OF RESEARCH, DEPARTMENT OF ANESTHESIOLOGY — LSU AND CHARITY HOSPITAL, 1976 TO DATE.

RESEARCH SOCIETIES, SCIENTIFIC AND EDUCATIONAL COMMITTEES:

1. MEMBER, SOCIETY OF EXPERIMENTAL BIOLOGY AND MEDICINE, 1941 TO DATE.
2. MEMBER (FOUNDERS GROUP), SOUTHERN SOCIETY FOR CLINICAL RESEARCH, 1946 TO DATE — EMERITUS.
3. MEMBER, SIGMA XI, NEW YORK UNIVERSITY CHAPTER, NEW YORK UNIVERSITY.
4. MEMBER, ALPHA OMEGA ALPHA, ELECTED TO COLLEGE OF PHYSICIANS & SURGEONS CHAPTER, COLUMBIA UNIVERSITY, MEMBER LSU & TULANE CHAPTERS.
5. MEMBER, SUBCOMMITTEE ON ANESTHESIA, ADVISORY COMMITTEE ON SURGERY, NATIONAL RESEARCH COUNCIL, 1951-62.
6. MEMBER, BOARD OF DIRECTORS, AMERICAN BOARD OF ANESTHESIOLOGY, 1960-72.

   CHAIRMAN, EXAMINATIONS COMMITTEE, 1963-66.
   VICE-PRESIDENT, 1966-67-68.
   PRESIDENT, 1968-69
   REGIONAL CHAIRMAN, COMMITTEE ON SURVEY EXAMINATIONS (LOUISIANA, MISSISSIPPI AND ALABAMA DISTRICT), 1948-57 (COMMITTEE DISBANDED).
7. HONORARY MEMBER, AMERICAN SOCIETY OF REGIONAL ANESTHESIA, 1975 TO DATE.

8. MEMBER, LIAISON COMMITTEE, AMERICAN MEDICAL ASSOCIATION AND AMERICAN BOARD OF ANESTHESIOLOGY (RESIDENCY REVIEW), 1956-60, 1965-67.
9. MEMBER, JOINT COMMITTEE, AMERICAN BOARD OF ANESTHESIOLOGY, AMERICAN SOCIETY OF ANESTHESIOLOGISTS AND SECTION ON ANESTHESIOLOGY, AMERICAN MEDICAL ASSOCIATION, 1962-68.
10. MEMBER (FOUNDERS GROUP), SOCIETY OF AMERICAN ACADEMIC CHAIRMEN, UNIVERSITY ANESTHESIA CHAIRMEN ASSOCIATION, 1967-1976.
11. MEMBER, INTERNATIONAL CONGRESS OF PHARMACOLOGY, 1969 TO DATE; PRESIDENT, 1969-70.
12. MEMBER, GOVERNOR McKEITHEN'S COMMITTEE ON TUBERCULOSIS, 1969-70 (DISSOLVED).
13. MEMBER, GOVERNOR McKEITHEN'S COMMITTEE ON GOALS FOR LOUISIANA — TASK FORCE FOR ENVIRONMENTAL HEALTH, 1969-70 (DISSOLVED IN 1970).
14. MEMBER, BOARD OF DIRECTORS, CANCER ASSOCIATION OF GREATER NEW ORLEANS, 1967 TO DATE.
15. MEMBER, LIAISON COMMITTEE, AMERICAN HOSPITAL ASSOCIATION AND AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, 1952-77.
16. MEMBER, SPECIAL AD HOC COMMITTEE ON LICENSURE OF HEALTH PERSONNEL, AMERICAN HOSPITAL ASSOCIATION, 1969-70 (DISSOLVED).
17. MEMBER, SUBCOMMITTEE ON SCOPE, REVISION OF U. S. PHARMACOPEIA XIV, XV, 1950-60; XVII, XVIII, 1960-70; REVISION COMMITTEE, 1975-80.
18. MEMBER, U. S. PHARMACOPEIAL CONVENTION (REPRESENTING LOUISIANA STATE MEDICAL SOCIETY), 1970 TO DATE.

19. CONSULTANT AND CONTRIBUTOR, U. S. DISPENSATORY (LIPPINCOTT), 1964 TO DATE.
20. MEMBER, REVISIONS COMMITTEE, NATIONAL FORMULARY, 1970-75.
21. MEMBER, SCIENTIFIC REVIEW PANEL, DRUG INTERACTIONS, AMERICAN PHARMACEUTICAL ASSOCIATION, 1971 TO DATE.
22. MEMBER, ADVISORY COMMITTEE TO COMMISSIONER LARRICK, FOOD AND DRUG ADMINISTRATION, 1963-65.
23. CHAIRMAN, ADVISORY COMMITTEE OF FDA ON ANESTHETIC AND RESPIRATORY DRUGS, 1966-70.
24. MEMBER, ADVISORY PANEL TO FDA ON REVIEW OF OVER-THE-COUNTER TOPICAL ANALGESICS, 1972 TO DATE.
25. MEMBER, ADVISORY PANEL TO FDA ON REVIEW OF OVER-THE-COUNTER ORAL CAVITY PREPARATIONS, 1974 TO DATE.
26. MEMBER, LIAISON COMMITTEE, AMERICN SOCIETY OF ANESTHESIOLOGISTS AND AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, 1965-77; CHAIRMAN, 1969-71.
27. MEMBER, COMMITTEE ON MANPOWER, AMERICAN SOCIETY OF ANESTHESIOLOGISTS, 1970-72.
28. MEMBER AND CHAIRMAN, COMMITTEE ON RESEARCH, AMERICAN SOCIETY OF ANESTHESIOLOGISTS, 1947-50.
29. CHAIRMAN, AD HOC COMMITTEE TO SELECT PUBLISHER FOR ANESTHESIOLOGY — AMERICAN SOCIETY OF ANESTHESIOLOGISTS, 1957.
30. MEMBER, COMMITTEE ON TRAUMA, AMERICAN COLLEGE OF SURGEONS.
31. MEMBER, NATIONAL SOCIETY FOR MEDICAL RESEARCH, 1966 TO DATE.

32. MEMBER, COMMITTEE ON LIAISON WITH NURSES AND PARAMEDICAL PERSONNEL, LOUISIANA STATE MEDICAL SOCIETY, 1972-75.

33. MEMBER, COMMITTEE ON LIAISON WITH MEDICAL SCHOOLS AND SAMA, LOUISIANA STATE MEDICAL SOCIETY, 1974-76.

34. CONSULTANT, COUNCIL ON DRUGS, AMERICAN MEDICAL ASSOCIATION, 1955-60.

35. MEMBER, COUNCIL ON DRUGS, AMA, 1964-72. (COUNCIL DISSOLVED IN 1972.)

    VICE-CHAIRMAN, 1964-67
    ACTING CHAIRMAN, SEPTEMBER 1967-68
    CHAIRMAN, 1968-71 (MAXIMUM TERM, THREE YEARS)

36. MEMBER, SECRETARY OF THE DEPARTMENT OF HEALTH, EDUCATION AND WELFARE FINCH'S AD HOC COMMITTEE ON EVALUATION OF TASK FORCE REPORT ON PRESCRIPTION DRUGS, JUNE, 1969.

37. MEMBER, MEDICAL COMMITTEE OF COMMITTEE ON ALCOHOLISM FOR GREATER NEW ORLEANS, 1969 TO DATE.

38. CHAIRMAN, FORMULARY COMMITTEE, LOUISIANA HEALTH AND HUMAN RESOURCES ADMINISTRATION, 1973 TO DATE.

39. MEMBER, NATIONAL COUNCIL ON DRUG ABUSE, 1973 TO DATE.

40. MEMBER, SUBCOMMITTEE ON DRUGS, AMERICAN COUNCIL OF OTOLARYNGOLOGY, 1974 TO DATE.

41. FELLOW, AMERICAN COLLEGE OF CLINICAL PHARMACOLOGY AND CHEMOTHERAPY, 1966 TO DATE.

42. FELLOW, AMERICAN SOCIETY FOR CLINICAL PHARMACOLOGY AND THERAPUETICS, 1966 TO DATE.

MEDICAL SOCIETIES:

1. MEMBER, INTERNATIONAL ANESTHESIA RESEARCH SOCIETY, 1941 TO DATE. (HONORARY PRESIDENT, 1950)
2. MEMBER (FOUNDERS GROUP), LOUISIANA SOCIETY OF ANESTHESIOLOGISTS.

   SECRETARY — TREASURER, 1948–51

   VICE-PRESIDENT, 1951–52

   MEMBER & CHAIRMAN, JUDICIARY COMMITTEE, 1975 TO DATE
3. MEMBER, BOARD OF DIRECTORS, AMERICAN SOCIETY OF ANESTHESIOLOGISTS, 1946–49 AND 1953–59.
4. MEMBER, BOARD OF GOVERNORS, AMERICAN COLLEGE OF ANESTHESIOLOGISTS, 1946–52 AND 1957–59.
5. MEMBER AND CO-FOUNDER WITH DR. PERRY VOLPITTO, SOUTHERN SOCIETY OF ANESTHESIOLOGISTS, 1948 TO DATE. PRESIDENT, 1952.
6. MEMBER (FOUNDERS GROUP), ASSOCIATION OF UNIVERSITY ANESTHETISTS, 1952 TO DATE. EXECUTIVE COMMITTEE, 1945–57; PRESIDENT, 1955–56.
7. FELLOW (FOUNDERS GROUP), ACADEMY OF ANESTHESIOLOGISTS, 1955 TO DATE.
8. CHAIRMAN, SECTION ON ANESTHESIOLOGY, AMERICAN MEDICAL ASSOCIATION, 1958–59.
9. MEMBER, EXECUTIVE COMMITTEE, SECTION ON ANESTHESIOLOGY, AMERICAN MEDICAL ASSOCIATION, 1958–60
10. HONORARY MEMBER, CUBAN SOCIETY OF ANESTHESIOLOGISTS, 1949.
11. HONORARY PRESIDENT, MEXICAN SOCIETY OF ANESTHESIOLOGISTS, 1954.

12. HONORARY MEMBER, VENEZUELAN SOCIETY OF ANESTHESIOLOGISTS, 1955 TO DATE.
13. HONORARY PRESIDENT, FOUNDERS MEETING, YUCATAN SOCIETY OF ANESTHESIOLOGISTS, 1965.
14. HONORARY MEMBER, HORACE WELLS SOCIETY, 1969 TO DATE.
15. HONORARY FELLOW, PHILIPPINE COLLEGE OF ANESTHESIOLOGISTS, 1973 TO DATE.
16. MEMBER, FACULTIES OF NURSE ANESTHESIA SCHOOLS, 1974 TO DATE. MEMBER, BOARD OF DIRECTORS, DISTRICT #7, 1974 TO DATE.
17. MEMBER, SOUTHERN MEDICAL ASSOCIATION, 1941 TO DATE (LIFE-TIME MEMBER). SECRETARY, SECTION ON ANESTHESIOLOGY, 1942-45. CHAIRMAN, SECTION ON ANESTHESIOLOGY, 1947-49.
18. MEMBER, NEW ORLEANS GRADUATE MEDICAL ASSEMBLY, 1942 TO DATE. CHAIRMAN, COMMITTEE ON ANESTHESIOLOGY, VARIOUS YEARS. SENIOR MEMBER, 1976 TO DATE.
19. MEMBER, AMERICAN COLLEGE OF ANGIOLOGY, 1955-59.
20. MEMBER, AMERICAN ASSOCIATION FOR THE ADVANCEMENT OF SCIENCE, 1955 TO DATE.
21. MEMBER, LOUISIANA HEART ASSOCIATION, 1955 TO DATE.
22. MEMBER, AMERICAN HEART ASSOCIATION, 1955 TO DATE.
23. MEMBER, INTERNATIONAL SOCIETY FOR COMPREHENSIVE MEDICINE, 1960 TO DATE.
24. FELLOW, SOUTHEASTERN SURGICAL CONGRESS, 1947 TO DATE.
25. FELLOW, AMERICAN SURGICAL ASSOCIATION, 1955-68. SENIOR MEMBER, 1968 TO DATE.

26. MEMBER (FOUNDERS GROUP), ASSOCIATION FOR SURGERY OF THE ALIMENTARY TRACT, 1960 TO DATE. SENIOR MEMBER 1965 TO DATE.
27. MEMBER, JAMES D. RIVES SURGICAL SOCIETY, 1965 TO DATE.
28. MEMBER, LOUISIANA THORACIC SOCIETY, 1962 TO DATE.
29. MEMBER (FOUNDERS GROUP), THORACOPHILUS CLUB, 1962 TO DATE (DISSOLVED IN 1968).
30. MEMBER, PAN-AMERICAN MEDICAL SOCIETY, 1965 TO DATE.
31. MEMBER, LOUISIANA HOSPITAL ASSOCIATION, 1966 TO DATE.
32. MEMBER, AMERICAN MEDICAL ASSOCIATION.
33. MEMBER, AMERICAN MEDICAL POLITICAL ACTION COMMITTEE (AMA).
34. MEMBER, LOUISIANA STATE MEDICAL SOCIETY.
35. MEMBER, LOUISIANA AMERICAN MEDICAL POLITICAL ACTION COMMITTEE (LSMS).
36. MEMBER, ORLEANS PARISH MEDICAL SOCIETY.
37. MEMBER, COLUMBIA COLLEGE ALUMNI ASSOCIATION, COLUMBIA UNIVERSITY, 1930 TO DATE.
38. MEMBER, ALUMNI ASSOCIATION, COLLEGE OF PHYSICIANS AND SURGEONS, COLUMBIA UNIVERSITY, 1934 TO DATE.
39. MEMBER, CENTURY CLUB, COLUMBIA UNIVERSITY ALUMNI ASSOCIATION, COLLEGE OF PHYSICIANS AND SURGEONS, 1934 TO DATE.
40. MEMBER, JOHN JAY ASSOCIATES, COLUMBIA COLLEGE, COLUMBIA UNIVERSITY, 1973 TO DATE.
41. MEMBER, COLUMBIA UNIVERSITY CLUB IN NEW ORLEANS, 1974 TO DATE.
41. HONORARY ALUMNUS, TULANE UNIVERSITY, 1973 TO DATE.

42. MEMBER, LSU MEDICAL FACULTY CLUB, 1965 TO DATE.

CONTRIBUTIONS TO MEDICINE AT CHARITY HOSPITAL OF LOUISIANA AT NEW ORLEANS:

1. DEVELOPED SADDLE BLOCK ANESTHESIA TECHNIQUE AND APPLIED IT TO SURGERY AND OBSTETRICS.
2. DEVELOPED "ADRIANI CIRCLE FILTER" FOR FORREGGER ANESTHESIA APPARATUS TO REMOVE CARBON DIOXIDE.
3. DEVELOPED (WITH DR. NICK ACCARDO) BRACHEAL PLEXUS BLOCK BY AXILLARY ROUTE.
4. FIRST USED ELECTRIC STIMULATOR TO LOCATE NERVES FOR REGIONAL NERVE BLOCK (WITH DR. JOHN PARMLEY).
5. DEVELOPED TECHNIQUE OF USING DIBICANE AND GLUCOSE FOR SPINAL ANESTHESIA. (NUPERCAINE)
6. FIRST USED CENTRAL ACTING MUSCLE RELAXANTS FOR TREATMENT OF TETANUS.
7. FIRST USED NALORPHINE AS ANTI-NARCOTIC FOR OVERDOSAGE OF NARCOTIC POISONING.
8. FIRST USED AND SUGGESTED THAT GAS CHROMATOGRAPHY WOULD BE USEFUL ANALYTICAL TECHNIQUE IN ANESTHESIOLOGY (WITH FRANK SUMMERS).
9. DEVISED METHOD (NOW WIDELY USED) FOR DETERMINING EFFICACY AND POTENCY OF LOCAL ANESTHETICS ON MUCOUS MEMBRANE (ELECTRICAL STIMULATION OF TIP OF TONGUE) — WITH DR. RICHARD ZEPPERNICK.
10. DEVISED METHOD FOR TESTING EFFACY OF TOPICAL ANALGESICS ON SKIN USING ELECTRICAL STIMULATOR TO SIMULATE ITCH AND PAIN (WITH H. DALILI).

11. FIRST USED SUCCINYL CHOLINE AS MUSCLE RELAXANT IN SOUTH.
12. FIRST MODIFIED ADULT ANESTHETIC APPARATUS AND APPLIED IT TO PEDIATRIC ANESTHESIA.
13. FIRST DEVISED "CRASH CART FOR USE FOR CARDIOPULMONARY RECUSSITATION (WITH JOHN PARMLEY).
14. FIRST USED HYDROXYZINE (VISTARIL — FOR PEDIATRIC PREMEDICATION).
15. FIRST MEASURED BLOOD LEVELS OF LOCAL ANESTHETICS AND CORRELATED THEM WITH SYSTEMIC TOXICITY (WITH D. CAMPBELL).
16. FIRST USED LIDOCAINE AS LOCAL ANESTHETIC IN SOUTH.
17. FIRST USED VINYL ETHER AS ANESTHETIC IN SOUTH.
18. FIRST USED HALOTHANE FOR ANESTHESIA IN LOUISIANA.
19. FIRST USED SECOBARBITAL IN CARBOWAX INTRAVENOUSLY AS ADJUNCT TO ANESTHESIA.
20. FIRST STUDIED THE MECHANICS, AIR FLOW, RESISTANCE AND OPTIMAL CONDITIONS OF OPERATION OF CARBON DIOXIDE ABSORBERS FOR ANESTHESIA (STUDIES BEGAN AT BELLEVUE HOSPITAL).
21. FIRST TO COMPARE VARIOUS VAROPRESSORS FOR PROLONGING EFFECT OF LOCAL ANESTHETICS INTRASPINALLY IN MAN.
22. FIRST TO STUDY HISTOLOGICAL EFFECTS OF LONG LASTING ANESTHETICS AND NEUROLYTIC AGENTS ON PERINEURAL AND NEURAL TISSUES.
23. FIRST TO USE CERVIAL PLEXUS BLOCK FOR TREATMENT OF ATYPICAL FACIAL NEURALGIA (WITH PAUL PENTACOST).

24. FIRST TO DEMONSTRATE THAT SILENT REGURGITATION INTO THE TRACHEA CAN BE PREVENTED BY USE OF CUFFED TUBES AND IS NOT PREVENTED BY PACKS.
25. ONE OF THE FIRST TO USE ULTRA SOUND TO MONITOR BLOOD PRESSURES IN CHILDREN.
26. FIRST TO SHOW THAT PLASTIC DISPOSABLE BREATHING BAGS ARE DANGEROUS AND CAUSE HIGH PRESSURE TO DEVELOP AND RUPTURE LUNG (WITH JOHN PARMLEY).
27. FIRST TO SHOW THAT MICROWAVE AND RADIOWAVE BLOOD WARMERS HEMOLIZE BLOOD (WITH H. DALILI).

1. ORGANIZED AND DIRECTED THE CHARITY HOSPITAL BLOOD PLASMA BANK.
2. ORGANIZED ANESTHESIOLOGY RESIDENCY AT CHARITY HOSPITAL (APPROVED FOR 35 YEARS).
3. ORGANIZED SCHOOL OF OPERATING ROOM TECHNICIANS AT CHARITY HOSPITAL (1963).
4. ORGANIZED DEPARTMENT OF INHALATION THERAPY AT CHARITY HOSPITAL (1941).
5. ORGANIZED RECOVERY ROOM (1947).
6. ORGANIZED BONE BANK (1950).
7. ORGANIZED DIAGNOSTIC AND THERAPEUTIC NERVE BLOCK CLINIC (1942) — (PAIN CLINIC).
8. ORGANIZED ACUPUNCTURE CLINIC (1975).
9. ORGANIZED RECORDS COMMITTEE TO MEET JOINT COMMISSION ON HOSPITAL ACCREDITATION STANDARDS.
10. ORGANIZED TISSUE COMMITTEE TO MEET JOINT COMMISSION ON HOSPITAL ACCREDITATION STANDARDS.
11. REORGANIZED INACTIVE INFECTION COMMITTEE (LATER BECAME DEPARTMENT OF INFECTION CONTROL).

12. ORGANIZED CHARITY HOSPITAL SURGICAL COMMITTEE.
13. ORGANIZED COMMITTEE OF L.S.U., TULANE AND CHARITY HOSPITAL BOARDS TO FORMULATE PLANS TO ORGANIZE THE HEALTH EDUCATION AUTHORITY OF LOUISIANA.
14. CHARTER MEMBER OF RESEARCH COMMITTEE AT CHARITY HOSPITAL, ORGANIZED BY O.P. DALY.
15. ORGANIZED SCHOOL OF ANESTHESIOLOGY, FLINT GOODRIDGE HOSPITAL, AND INTEGRATED WITH CHARITY HOSPITAL SCHOOL. WAS CONSULTANT DIRECTOR FROM 1949 TO 1962.
16. ORGANIZED AND CONDUCTED ANNUAL REFRESHER COURSE FOR NURSE ANESTHETISTS IN CONJUNCTION WITH LA. HEART ASSOC., 1958-73.
17. ESTABLISHED ANESTHESIA RESEARCH FUND AT CHARITY HOSPITAL.
18. FIRST TO COMPILE PROCEDURE AND REGULATIONS MANUAL FOR OPERATING ROOM, RECOVERY ROOM, INHALATION THERAPY DEPT., AND BLOOD BANK.

HOSPITAL POSITIONS AND APPOINTMENTS:

1. ASSISTANT VISITING ANESTHETIST, BELLEVUE HOSPITAL, NEW YORK, 1938-41.
2. DIRECTOR, DEPARTMENT OF ANESTHESIOLOGY, CHARITY HOSPITAL, NEW ORLEANS, 1941-76. EMERITUS — 1976.
3. DIRECTOR, DEPARTMENT OF INHALATION THERAPY, CHARITY HOSPITAL, 1941-70.
4. SENIOR VISITING SURGEON (ANESTHESIA), TULANE AND LSU DIVISIONS, CHARITY HOSPITAL, 1941 TO DATE.
5. MEMBER, CHARITY HOSPITAL RESEARCH COMMITTEE, 1942-72.

6. DIRECTOR, BLOOD PLASMA BANK, CHARITY HOSPITAL, 1944-70.
7. ASSISTANT DIRECTOR, CHARITY HOSPITAL, 1950-64. ASSOCIATE DIRECTOR, 1966-76. (IN CHARGE OF OPERATING AND RECOVERY ROOMS AND SURGICAL AFFAIRS IN THE HOSPITAL.)
8. CHAIRMAN, CHARITY HOSPITAL RECORDS COMMITTEE, 1957-64. (EX-OFFICIO — 1965-69)
9. MEMBER, ADVISORY COMMITTEE TO EXECUTIVE COMMITTEE, VISITING STAFF CHARITY HOSPITAL, 1957-59. (EX-OFFICIO MEMBER, 1960-69)
10. ACTING CHAIRMAN, INFECTIONS COMMITTEE, CHARITY HOSPITAL, 1960-69.
11. MEMBER (EX-OFFICIO), CHARITY HOSPITAL TISSUE COMMITTEE, 1960-69.
12. MEMBER, CHARITY HOSPITAL PHARMACY AND THERAPEUTICS COMMITTEE, 1960 TO DATE.
13. MEMBER AND CHAIRMAN, CHARITY HOSPITAL SUBCOMMITTEE ON SURGICAL AFFAIRS, 1964-69.
14. MEMBER, DISASTER PLANNING COMMITTEE, NEW ORLEANS HOSPITAL COUNCIL, 1966-67.
15. MEMBER, UTILIZATION REVIEW COMMITTEE, CHARITY HOSPITAL, 1966-69.
16. CHAIRMAN, JOINT ADVISORY COMMITTEE (LSU, TULANE AND CHARITY HOSPITAL) TO LONG-RANGE PLANNING COMMITTEE TO ESTABLISH HEALTH EDUCATION AUTHORITY OF LOUISIANA, 1966-69. (ACT 112)
17. MEMBER, LONG-RANGE PLANNING COMMITTEE, CHARITY HOSPITAL, 1966-70.
18. HOSPITAL PLANNING COORDINATOR, CHARITY HOSPITAL EXPANSION AND RENOVATION, 1966-70.
19. CONSULTANT TO BOARD OF ADMINISTRATORS, CHARITY HOSPITAL, 1969-72.

20. MEMBER, ADVISORY COMMITTEE ON ACUPUNCTURE TO COMMITTEE ON HEALTH, LOUISIANA LEGISLATURE, 1974-76.

CERTIFICATIONS:

1. DIPLOMATE, AMERICAN BOARD OF ANESTHESIOLOGY, CERTIFIED 1940.
2. FELLOW, AMERICAN COLLEGE OF ANESTHESIOLOGISTS, CERTIFIED 1941.
3. LICENSED (MEDICAL), STATE OF NEW YORK, 1934; STATE OF LOUISIANA, 1941.

CONSULTANTSHIPS (CONSULTING ANESTHESIOLOGIST OR PHARMACOLOGIST TO):

1. FOOD AND DRUG ADMINISTRATION, BUREAU OF MEDICINE, 1963-70.
2. FLINT-GOODRIDGE HOSPITAL, NEW ORLEANS, LOUISIANA, 1941 TO DATE.
3. U.S. PUBLIC HEALTH SERVICE HOSPITAL, NEW ORLEANS, LOUISIANA, 1947-76.
4. VETERANS ADMINISTRATION HOSPITAL, NEW ORLEANS, LOUISIANA, 1949 TO DATE.
5. VETERANS ADMINISTRATION HOSPITAL, ALEXANDRIA, LOUISIANA, 1969-76.
6. HOTEL DIEU, NEW ORLEANS, LOUISIANA, 1950 TO DATE.
7. OCHSNER FOUNDATION HOSPITAL, NEW ORLEANS, LOUISIANA, 1960 TO DATE.
8. PLAQUEMINE GENERAL HOSPITAL, PLAQUEMINE, LOUISIANA, 1964-69.
9. KEESLER AIR FORCE BASE HOSPITAL, BILOXI, MISSISSIPPI, 1965-76.
10. CONSULTANT IN PHARMACOLOGY, POISON CONTROL CENTER, NEW ORLEANS, 1966 TO DATE.

11. CONSULTANT, PHARMACOLOGY AND ANESTHESIOLOGY, LOUISIANA HEALTH AND HUMAN RESOURCES ADMINISTRATION, MARCH 1976 TO DATE.

AWARDS AND HONORS:

1. DISTINGUISHED SERVICE AWARD OF AMERICAN SOCIETY OF ANESTHESIOLOGISTS, 1949.
2. AWARDED OLDSMOBILE AND BOOK OF TESTIMONIAL LETTERS BY FORMER CHARITY HOSPITAL RESIDENTS IN ANESTHESIOLOGY AT ANNUAL MEETING, SOUTHERN SOCIETY OF ANESTHESIOLOGISTS, MEMPHIS, TENNESSEE, 1954.
3. CERTIFICATES OF MERIT, MAYORALTY OF NEW ORLEANS (FOR AUTHORSHIP OF BOOKS AND OTHER ACTIVITIES), 1951, 1967, 1969.
4. ROLLAND J. WHITACRE LECTURESHIP, CLEVELAND, OHIO, 1956.
5. DISTINGUISHED SERVICE AWARD OF INTERNATIONAL ANESTHESIA RESEARCH SOCIETY, 1957.
6. GUEDEL MEDAL AND ESSAYIST FOR GUEDEL LECTURE, LOS ANGELES, CALIFORNIA, 1959.
7. PLAQUE, MEMBER FOUNDERS GROUP, HOLY CROSS DEVELOPMENT PROGRAM, HOLY CROSS HIGH SCHOOL, NEW ORLEANS, LOUISIANA.
8. HONORARY COLONEL, STAFF OF GOVERNOR JOHN McKEITHEN OF LOUISIANA, 1964-72.
9. HONORARY SENATOR, LOUISIANA STATE LEGISLATURE, 1975 TO DATE.
10. GOLD MEDAL FOR DISTINGUISHED ACHIEVEMENTS IN MEDICINE OF AN INTERNATIONAL SCOPE, ALUMNI OF COLLEGE OF PHYSICIANS AND SURGEONS, COLUMBIA UNIVERSITY, 1967.

11. SILVER MEDALLION FOR BRINGING DISTINCTION TO THE UNIVERSITY, COLLEGE OF PHYSICIANS AND SURGEONS, COLUMBIA (IN COMMEMORATION OF 200TH. ANNIVERSARY), 1967.
12. RALPH M. WATERS MEDAL AND AWARD IN ANESTHESIOLOGY (INTERNATIONAL — 3RD. RECIPIENT, FIRST AMERICAN), 1968.
13. KNIGHT COMMANDER IN THE ORDER OF MERIT OF THE ITALIAN REPUBLIC, 1969. (HIGHEST HONOR AWARDED TO A CIVILIAN BY THE ITALIAN GOVERNMENT).
14. NATIONAL ITALIAN AMERICAN OF THE YEAR, GREATER NEW ORLEANS ITALIAN CULTURAL SOCIETY, 1969.
15. NEW ORLEANS ADRIANI DAY, PROCLAIMED BY MAYOR VICTOR SCHIRO, MARCH 18, 1969.
16. THE HORACE WELLS AWARD IN ANESTHESIOLOGY FOR 1969 — HORACE WELLS SOCIETY.
17. FIRST LECTURER — FREDERICK P. HAUGEN LECTURESHIP, PORTLAND, OREGON, 1970.
18. TRAVENOL-BAXTER LECTURESHIP (INTERNATIONAL ANESTHESIA RESEARCH SOCIETY), 1972.
19. ANNUAL DISTINGUISHED LECTURER FOR 1974, SOUTHERN SOCIETY OF ANESTHESIOLOGISTS (PLAQUE).
20. CERTIFICATE OF MERIT AND HONORABLE MENTION FOR SCIENTIFIC EXHIBITS AT THE AMERICAN MEDICAL ASSOCIATION, SOUTHERN MEDICAL ASSOCIATION, INTERNATIONAL ANESTHESIA RESEARCH SOCIETY, AMERICAN SOCIETY OF ANESTHESIOLOGISTS, AND LOUISIANA STATE MEDICAL SOCIETY, VARIOUS YEARS.

21. COUNCIL ON DRUGS, AMERICAN MEDICAL SOCIETY, PLAQUE FOR APPRECIATION OF TEN YEARS OF SERVICE, 1972.
22. MONTE M. LEMANN AWARD FROM LOUISIANA CIVIL SERVICE LEAGUE FOR CIVIC ACTIVITIES IN UPGRADING MERIT SYSTEM IN LOUISIANA, 1975.
23. CERTIFICATE OF APPRECIATION FOR 35 YEARS OF SERVICE AT CHARITY HOSPITAL, BOARD OF ADVISORS, CHARITY HOSPITAL AND COMMISSIONER OF HEALTH AND HUMAN RESOURCES OF LOUISIANA, 1975.
24. CERTIFICATE OF WELCOME AND APPRECIATION, MAYOR MANDANICI, BRIDGEPORT, CONNECTICUT, MARCH, 1976.
25. KEYNOTE SPEAKER, DEDICATION OF ST. VINCENT'S NEW HOSPITAL, BRIDGEPORT, CONNECTICUT, MARCH, 1976.
26. PLAQUE IN APPRECIATION OF CONTRIBUTIONS TO MEDICINE, ST. VINCENT'S HOSPITAL, BRIDGEPORT, CONNECTICUT.
27. PLAQUE FROM U.S.P. IN APPRECIATION OF SERVICES A MEMBER OF U. S. A. REVISIONS COMMITTEE.
28. FIRST LECTURE IN PHARMACOLOGY AT LSU SCHOOL OF MEDICINE, SHREVEPORT, LOUISIANA.
29. INVITED TO DONATE PERSONAL PAPERS AND LETTERS TO THE NATIONAL LIBRARY OF MEDICINE, NATIONAL INSTITUTES OF HEALTH, HEW.
30. INVITED TO DONATE PAPERS TO WOOD LIBRARY MUSEUM, AMERICAN SOCIETY OF ANESTHESIOLOGY.
31. JOHN ADRIANI COMMEMORATIVE FUND FOR PORTRAIT AND LECTURESHIP ESTABLISHED BY FORMER RESIDENTS AND STUDENTS.

32. PLAQUE FROM LOUISIANA STATE NURSE ANESTHETISTS IN APPRECIATION OF CONTRIBUTIONS TO NURSE ANESTHESIA OVER 35 YEARS.

SOCIETIES — CIVIC:

1. MEMBER, NATIONAL FIRE PROTECTION ASSOCIATION.
2. MEMBER, FEDERATION OF WILD LIFE AND FISHERIES OF LOUISIANA.
3. MEMBER, HORSESHOE CLUB, 1956 TO DATE.
4. HONORARY ASSOCIATE FIRE MARSHAL, STATE OF LOUISIANA, 1964-68.
5. MEMBER (FOUNDERS GROUP), HOLY CROSS DEVELOPMENT PROGRAM, 1964 TO DATE.
6. MEMBER, NATIONAL COUNCIL ON CRIME AND DELINQUENCY, 1966 TO DATE.
7. MEMBER, LOUISIANA CIVIL SERVICE LEAGUE, 1966 TO DATE. BOARD OF GOVERNORS, 1970 TO DATE.
8. MEMBER (LIFETIME), GREATER NEW ORLEANS ITALIAN CULTURAL SOCIETY, 1969.
9. MEMBER, BUREAU OF GOVERNMENTAL RESEARCH, NEW ORLEANS, 1973 TO DATE.
10. MEMBER, PUBLIC AFFAIRS RESEARCH COUNCIL OF LOUISIANA, 1973 TO DATE.
11. MEMBER, METROPOLITAN AREA COMMITTEE OF NEW ORLEANS, 1974 TO DATE.

LISTINGS:

1. WHO'S WHO IN THE WORLD.
2. WHO'S WHO IN WORLD SCIENCE.
3. WHO'S WHO IN SCIENCE.
4. WHO'S WHO IN THE UNITED STATES.

5. WHO'S WHO IN AMERICA (MARQUIS).
6. WHO'S WHO IN THE SOUTHWEST.
7. PERSONS OF IMPORTANCE IN THE UNITED STATES.
8. DIRECTORY OF MEDICAL SPECIALISTS.
9. LEADERS IN AMERICAN SCIENCE.
10. NATIONAL CYCLOPEDIA OF AMERICAN BIOGRAPHY.
11. COLUMBIA COLLEGE (COLUMBIA UNIVERSITY) ALUMNI REGISTER (MARQUIS).
12. WISDOM HALL OF FAME.
13. IMPORTANT PERSONALITIES IN THE SOUTH.
14. DICTIONARY OF AMERICAN BIOGRAPHY (MARQUIS).
15. OUTSTANDING AND PROMINENT AMERICANS.
16. DICTIONARY OF INTERNATIONAL BIOGRAPHY.
17. NATIONAL REGISTER OF PROMINENT AMERICANS.
18. COMMUNITY LEADERS OF AMERICA.
19. AMERICAN MEN AND WOMEN OF SCIENCE.

EDITORSHIPS:

1. EDITOR, AMERICAN LECTURE SERIES ON ANESTHESIA. CHARLES C. THOMAS, PUBLISHER, SPRINGFIELD, ILLINOIS, 1950 TO DATE.
2. EDITOR, ANESTHESIOLOGY (JOURNAL OF THE AMERICAN SOCIETY OF ANESTHESIOLOGY), 1958–67 — NINE YEAR MAXIMUM TERM.
3. EDITOR (ANESTHESIA), DORLAND'S MEDICAL DICTIONARY, SAUNDERS, 1969 TO DATE.
4. CONSULTING EDITOR, THE GENERAL PRACTITIONER, 1950-76.
5. CONSULTING EDITOR, SURGERY, 1949-71.

6. CONSULTING EDITOR, O.S., 1952-53 (DISCONTINUED).
7. CONSULTING EDITOR, THE RESIDENT, 1952 TO DATE.
8. CONSULTING EDITOR, THE FAR EAST JOURNAL OF ANESTHESIA, 1952-60 (DISCONTINUED).
9. CONSULTING EDITOR, SURVEY OF ANESTHESIOLOGY, 1956 TO DATE.
10. CONSULTANT (AD HOC), THE MEDICAL LETTER.
11. MEMBER OF ADVISORY BOARD, MEDICAL TRIBUNE, 1960 TO DATE.
12. CONSULTANT (EDITORIAL), MERCK INDEX, 7TH. ED., 1960.
13. CONSULTING EDITOR, INTERNATIONAL AUDIO DIGEST, 1965 TO DATE.
14. MEMBER, EDUCATIONAL FILM PRODUCTION MEDICAL ADVISORY BOARD, 1966 TO DATE.
15. CONSULTING EDITOR, INTERNATIONAL CORRESPONDENCE SOCIETY OF ANESTHESIOLOGY.
16. CONSULTING EDITOR, AD HOC PHYSICIAN'S DRUG MANUAL, 1950 TO DATE.
17. CONSULTING EDITOR, COMMUNICATIONS IN ANESTHESIOLOGY, 1968 TO DATE.
18. CONSULTING EDITOR, EXCERPTA MEDICA, 1965 TO DATE.
19. CONSULTING EDITOR, JOURNAL OF CONTINUING EDUCATION, 1973 TO DATE.
20. MEMBER, EDITORIAL ADVISORY BOARD, AMERICAN ACADEMY OF FAMILY PHYSICIANS, 1948-75.
21. CHAIRMAN, AD HOC COMMITTEE OF COUNCIL ON DRUGS TO WRITE AND EDIT AMERICAN MEDICAL ASSOCIATION'S DRUG REFERENCE BOOK, *ADE*, 1969, ED.I.

22. CONSULTING EDITOR (AD HOC), JAMA.
23. CONSULTING EDITOR (AD HOC), SCIENCE.
24. CONSULTING EDITOR (AD HOC), SOUTHERN MEDICAL JOURNAL.

PAPERS:

APPROXIMATELY 650 SCIENTIFIC AND MEDICAL PAPERS AND CHAPTERS IN TEXTBOOKS.

EXHIBITS:

THIRTY-FOUR CONSECUTIVE SCIENTIFIC EXHIBITS ON ANESTHESIOLOGY AT ANNUAL MEETINGS OF AMERICAN MEDICAL ASSOCIATION; ALSO AT LOUISIANA STATE MEDICAL SOCIETY, AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INTERNATIONAL ANESTHESIA RESEARCH SOCIETY AND SOUTHERN MEDICAL ASSOCIATION.

BOOKS:

1. *PHARMACOLOGY OF ANESTHETIC DRUGS*: CHARLES C. THOMAS, SPRINGFIELD, 1ST. ED., 1939; 5th. ED., 1970; 5TH. PRINTING — 1977.
2. *CHEMISTRY OF ANESTHESIA*: CHARLES C. THOMAS, SPRINGFIELD, 1ST. ED., 1946.
3. *CHEMISTRY AND PHYSICS OF ANESTHESIA*: CHARLES C. THOMAS, SPRINGFIELD, 1ST. ED., 1962; 7TH. PRINTING — 1977.
4. *NERVE BLOCKS*: CHARLES C. THOMAS, SPRINGFIELD, 1954.
5. *SELECTION OF ANESTHESIA*: CHARLES C. THOMAS, SPRINGFIELD, 1955.
6. *THE RECOVERY ROOM: A SYMPOSIUM*: CHARLES C. THOMAS, SPRINGFIELD, 1958 (WITH JOHN PARMLEY).
7. *FUNDAMENTALS OF GENERAL ANESTHESIA FOR STUDENTS AND PRACTITIONERS OF DENTISTRY*: CHARLES C. THOMAS, SPRINGFIELD, 1959.

8. *TECHNIQUES AND PROCEDURES OF ANESTHESIA*: CHARLES C. THOMAS, SPRINGFIELD, 1ST. ED., 1946; 3RD. ED., 1964.
9. *APPRAISAL OF CURRENT CONCEPTS IN ANESTHESIOLOGY, VOL. I*: MOSBY, ST. LOUIS, 1961.
10. *APPRAISAL OF CURRENT CONCEPTS IN ANESTHESIOLOGY, VOL. II*: MOSBY, ST. LOUIS, 1964.
11. *APPRAISAL OF CURRENT CONCEPTS IN ANESTHESIOLOGY, VOL. III*: MOSBY, ST. LOUIS, 1964.
12. *APPRAISAL OF CURRENT CONCEPTS IN ANESTHESIOLOGY, VOL. IV*: MOSBY, ST. LOUIS, 1969.
13. *REVISION OF LABAT'S REGIONAL ANESTHESIA*: W. B. SAUNDERS, PHILADELPHIA, 3RD. ED., 1967. REPRINTED 1969.

BOOKS EDITED:

AMERICAN LECTURE SERIES — CHARLES C. THOMAS, PUBLISHER JOHN ADRIANI, EDITOR

1. NARCOTIC ANTAGONISTS — FOLDES
2. ANATOMY FOR THE ANESTHETIST — DORNETTE
3. THE VALUE OF THE HEMATOCRIT IN ANESTHESIOLOGY — ALBERT
4. BLOOD VOLUME — ALBERT
5. ANESTHESIA FOR THE POOR RISK PATIENT — MUSHIN
6. THE RECOVERY ROOM — ADRIANI & PARMLEY
7. CLINICAL APPLICATION OF DIAGNOSTIC AND THERAPEUTIC NERVE BLOCK — BONICA
8. GERIATRIC ANESTHESIA — LORHAN

9. RESUSCITATION OF THE NEW BORN — RUSS
10. ANESTHESIA AND THE LAW — WASMUTH
11. SPINAL ANESTHESIA — DILLON
12. INHALATION THERAPY — SAKLAD
13. ELEMENTS OF PEDIATRIC ANESTHESIA — STEPHEN
14. METABOLIC EFFECTS OF ANESTHESIA — NGAI AND PAPPER
15. HISTOPATHOLOGIC EFFECTS OF LOCAL ANESTHETIC DRUGS — PIZZOLATO AND MANNHEIMER
16. MUSCLE RELAXANTS IN CLINICAL MEDICINE — FOLDES
17. SADDLE BLOCK ANESTHESIA — PARMLEY
18. ELECTRICAL ANESTHESIA — SMITH
19. PATHOLOGY FOR THE ANESTHETIST — SMITH
20. HYPOTENSIVE ANESTHESIA — LITTLE
21. ELECTROENCEPHALOGRAPHY FOR THE ANESTHETIST — BRECHNER, WALTER AND DILLON
22. ELECTROENCEPHALOGRAPHY IN ANESTHESIOLOGY — FAULCONER AND BICKFORD
23. MANUAL OF ANESTHESIOLOGY FOR RESIDENTS — PAPPER, NGAI AND SCHWARTZ
24. HOSPITAL PLANNING FOR THE ANESTHETIST — DORNETTE
25. STRUCTURAL FORMS OF ANESTHETIC COMPUNDS — MATHEWSON
26. ARTIFICIAL VENTILATORS — HEIRONIMUS
27. DEATHS IN THE OPERATING ROOM — BOBA
28. HYPERBARIC OXYGENATION — PITTINGER
29. ANESTHESIA FOR SURGERY OF THE HEART — KEOWN

30. HYPOTHERMIC ANESTHESIA — VIRTUE
31. PHYSIOLOGY OF OBSTETRIC ANESTHESIA — MARX AND ORKIN

BOOKS EDITED:

CONSULTATION EDITING AND PROOFREADING OF PORTIONS OF:

1. U. S. DISPENSATORY — OSLO ET AL., LIPPINCOTT COMPANY
2. DORLAND'S MEDICAL DICTIONARY
3. NEW AND NON-OFFICIAL DRUGS — COUNCIL ON DRUGS, AMA — SELECTED MONOGRAPHS
4. NEW DRUGS, AMA — 1966, 1967, 1968
5. U. S. P. XVII — MACK PUBLISHING COMPANY — 1965
6. MERCK INDEX — 1960
7. AMA DRUG REFERENCE BOOK

In the
United States Court of Appeals
For the Fifth Circuit

DR. EDWIN G. HYDE,

Plaintiff-Appellant

v.

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 and THE EAST JEFFERSON HOSPITAL BOARD,

No. 81-3091

Defendants-Appellees

MOTION TO DISMISS APPEAL

Appelles, JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 and THE EAST JEFFERSON HOSPITAL BOARD, move the Court to dismiss the appeal herein, with each party to pay its own costs, on the ground that the cause has become moot for the following reasons:

1. Petitioner, DR. EDWIN G. HYDE, sought declaratory and injunctive relief relative to the defendants-appellees exclusion of petitioner from the staff of East Jefferson General Hospital based on said Hospital's policy declaring a closed Department of Anesthesia using only the services of an Anesthesiology Group contracting with the Hospital.

2. The policy of Jefferson Parish Hospital District No. 2 and the East Jefferson Hospital Board has changed and the staff in Anesthesia is now open and Dr. Hyde and

any other anesthesiologists are welcome to apply for membership on the medical staff of East Jefferson General Hospital.

Respectfully Submitted:

MMAHAT, GAGLIANO,
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In
The United States Court Of Appeals
For The Fifth Circuit

No. 81-3091

DR. EDWARD G. HYDE,

Plaintiff-Appellant

v.

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2,
AND THE EAST JEFFERSON HOSPITAL BOARD,

Defendants-Appellees.

Appeal from
the United States District Court
for the Eastern District of Louisiana

Before CLARK, REAVLEY and RANDALL, Circuit Judges.

BY THE COURT:

IT IS ORDERED that appellees' motion to dismiss the appeal is denied.

Office-Supreme Court, U.S.
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CLERK

NO. 82-1031

In the Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 and EAST JEFFERSON HOSPITAL BOARD,

PETITIONERS

V.

DR. EDWIN G. HYDE,

RESPONDENT

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

Whether a tying arrangement that restrains competition among anesthesiologists is immune from the rule of per se illegality under the Sherman Act solely because the services involved are rendered in a hospital?

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STATEMENT OF THE CASE

1. *Course of proceedings below.*

This action was brought by the respondent, Dr. Edwin G. Hyde ("Dr. Hyde") for declaratory and injunctive relief concerning his exclusion from the medical staff at East Jefferson General Hospital ("the Hospital"), located in Jefferson Parish, Louisiana. Dr. Hyde alleged and the petitioners admitted that he was denied admission to the medical staff solely because the Hospital was party to an "exclusive contract" with a group of anesthesiologists named Roux & Associates. Doctor Hyde asked the district

court to declare that the actions of the petitioners violated several constitutional and statutory provisions, including Section 1 of the Sherman Act. Dr. Hyde contended that the exclusive contract between the Hospital and Roux & Associates violated the Sherman Act's Rule of Reason, and also constituted a per se illegal tying arrangement in that users of the Hospital's surgical facilities (the tying product) also were compelled to purchase anesthesia services from Roux & Associates.

Following a trial on the merits, the district court entered Findings of Fact and Conclusions of Law denying all of Dr. Hyde's claims. *Hyde v. Jefferson Parish Hospital District No. 2,* 513 F.Supp. 532 (E.D. La. 1981). Although the district court found that exclusive contract did create a tying arrangement, it held that "the per se rules used in antitrust cases governing regular commercial activities should not be made automatically applicable to cases involving professional activities." *Id.* at 542. The district court upheld the tying arrangement under a Rule of Reason analysis.

The decision of the district court was reversed by the United States Court of Appeals for the Fifth Circuit. *Hyde v. Jefferson Parish Hospital District 2.,* 686 F.2d 286 (5th Cir. 1982). Relying upon this Court's decision in *Arizona v. Maricopa County Medical Society,* __ U.S. __, 102 S.Ct. 2466 (1982), the court of appeals rejected the petitioners' arguments that a lack of "antitrust experience in the health care industry" and "the professional nature of the services" involved precluded application of the normal rule of per se illegality. *Id.* at 293. The court concluded that the tying arrangement created by the exclusive contract was illegal under the per se rule of *Northern Pacific Ry. Co. v. United States,* 356 U.S. 1, 78 S.Ct. 514 (1958) and held that

Dr. Hyde was entitled to the injunctive relief he sought. *Id.* at 294.

2. *Factual Background.*

The Hospital is owned and operated by the petitioner, Jefferson Parish Hospital District No. 2 ("the District"), which was created pursuant to Louisiana law by Jefferson Parish, Louisiana as a political subdivision of the state. The geographic boundaries of the District encompass only that part of Jefferson Parish located on the East Bank of the Mississippi River. Under state law, the only purposes of the District are to own and operate hospitals within its geographic boundaries and to provide hospital and other health services to residents of the District. La. R.S. 46:1052.

The Hospital is the only public hospital within the District and approximately 70 percent of the patients admitted to the Hospital are residents of the District. Approximately 30 per cent of all hospital admissions of District residents are to the Hospital. 513 F.Supp. at 539.

The petitioner, East Jefferson Hospital Board ("the Board"), was appointed by Jefferson Parish pursuant to state law to govern the operation of the District. One of the Board's statutory duties is to make appointments to the Hospital's medical staff "upon the recommendations of the physicians who are authorized to practice within the hospital." La. R.S. 46:1058. Pursuant to state law, the Hospital's medical staff is organized as an entity separate and apart from the Hospital itself. *Id.* The medical staff operates under its own set of by-laws and elects its own officers and committees.

All applications for appointment to the medical staff are directed initially to the medical staff office, which verifies the information furnished by the applicant. The medical staff credentials committee then reviews the applicant's qualifications and submits a recommendation to the medical staff executive committee. The executive committee also reviews the application and submits its recommendation to the Board for approval.

Dr. Hyde applied for medical staff appointment in July, 1977. The medical staff credentials committee reviewed the application in accordance with the medical staff by-laws, and it recommended Dr. Hyde's appointment. The medical staff executive committee also reviewed the application and submitted a recommendation to the Board that Dr. Hyde be appointed.

Despite these favorable recommendations, the Board voted in October, 1977 to deny Dr. Hyde admission to the medical staff. Dr. Hyde was notified of the Board's decision by letter from the Hospital's executive director stating that the application had been denied "in view of the exclusive nature of the contract between the Hospital and Roux & Associates and due to the fact that we have no openings in the Department of Anesthesia." The executive director explained at trial that his statement that there were "no openings in the Department of Anesthesia" meant that Roux & Associates, the anesthesia group that had an exclusive contract with the Hospital, did not intend to employ Dr. Hyde. 513 F.Supp. 537.

The exclusive contract cited as the basis for the Board's denial of Dr. Hyde's application was the second of two contracts between the Hospital and Roux & Associates. The first contract, executed in February, 1971,

explicitly granted to Roux & Associates the exclusive right to provide anesthesiology services at the Hospital. However, when a second contract was executed in January, 1976, the exclusivity provision was deleted at the request of the group's president, Dr. Kermit Roux. At trial, Dr. Roux explained the reason for his request:

> Q. The Judge asked you if in fact when the 1976 contract was negotiated and executed, you asked that the language calling for the exclusion of the other anesthesiologists be deleted from the contract.
>
> A. Yes, sir.
>
> Q. So that it would no longer be a part of the contract?
>
> A. Yes, sir. The reason we did that, there were a number of reasons. There was this other group that had requested to come practice there and led us to believe that some physicians preferred them to give their anesthetics. And if that were true, then I think they should be allowed to practice.
>
> The other reason is pretty much what you have alluded to, I didn't want to be there on the basis of hiding behind a contract. If I couldn't provide the service as best I could, then someone else ought to have a shot at it.
>
> And I have been told by people a number of times that, you're hiding behind the contract because it gives you exclusive privileges "exclusive privileges" and doesn't let anyone else come. And I don't believe that that's the way medicine should be practiced. It should be practiced on the basis of the person whom the physician or the patient feels can do the best job, should be their physician.

> So, we finally got them to delete that part of the contract.

686 F.2d at 288 n. 2. Although Dr. Roux obtained a change in the language of the contract because he felt the practice of medicine should be competitive rather than exclusive, the petitioners continued to interpret another provision of the contract as granting to Roux & Associates the exclusive right to provide anesthesia services at the Hospital. 513 F.Supp. 536.

The 1976 contract provided for a sharing of fees between the Hospital and Roux & Associates. The fees, however, were determined by Roux & Associates. The financial arrangement was described by the district court as follows:

> Ellis [the Hospital's executive director] testified that the hospital charges patients one fee for the professional services rendered by the anesthesiologist and for the anesthesia services provided by the hospital. The hospital pays the salaries of the nurses and purchases the equipment and supplies for the anesthesia department. A large number of the supplies are purchased from out of state. It also provides housekeeping, record keeping and maintenance services to the department.
>
> The anesthesiologist determines the fee for the anesthesia serivce provided dependent upon the complexity and length of the operation performed. The hospital deducts 8% for bad debts, charity and other write offs from the gross receipts of the department and 50% of the remainder is paid to Roux and Associates for its professional services.

513 F.Supp. at 536.

The petitioners do not seriously dispute that the exclusive contract directly restrains competition among anesthesiologists by precluding any patient or surgeon using the Hospital's operating room facilities from selecting any anesthesiologist other than a member of Roux & Associates. In addition, there was undisputed evidence at trial that the exclusive contract also restrains competition among anesthesiologists indirectly by limiting the total number of anesthesiologists available to serve patients in the market. The court of appeals described the anticompetitive effects of the contract as follows:

> In the course of presenting his case that the exclusive contract between the hospital and Roux and Associates violates the Sherman Anti-Trust Act, Dr. Hyde pointed out a number of "anti-competitive" effects that flow from the agreement. Basic to a discussion of these effects is an understanding of the manner in which the specialty of anesthesiology is practiced. Although the specialty of anesthesiology is indeed a very important and demanding one, the anesthesiologist is only involved in the medical decision-making process after the initial decision between the patient and surgeon that surgery is the indicated course of treatment. It is not surprising, therefore, that an anesthesiologist is normally selected by the surgeon, rather than the patient, based on familiarity gained through a working relationship. Obviously, the surgeons who practice at East Jefferson Hospital do not gain familiarity with any anesthesiologists other than Roux and Associates. Dr. Hyde argues that his is an especially egregious case because he has a more personal relationship with a great number of his patients than many anesthesiologists. This is because he specializes in obstetric anesthesiology

and, more particularly, the administration of epidural anesthetics. The exclusive contract, therefore, prohibits patients as well as surgeons from selecting him. Another twist which is important to an understanding of the specialty is that more than in any other medical specialty, anesthesiologists have been confronted with the growth of a paraprofessional counterpart—the anesthetist. Herein lies the actual basis for the hospital's actions in this case. While it is true that the tying of anesthesia services to operating rooms in the instant case did not lead to a higher charge for anesthesia services, it accomplished just as dramatic an effect by increasing the hospital's profit. The hospital realizes a substantial profit from its practice of supplementing a small contract group of anesthesiologists with a much larger group of lower priced anesthetists. Furthermore, this practice lacks candor; the patient is not informed that he will be billed for the services of an anesthesiologist who may have had very little contact with his case.

The exclusive contract spawns a number of anticompetitive effects. First, the tie prevents anesthesiologists from entering that part of the anesthesia services market which the hospital controls. This prohibition of competition not only serves indirectly to artificially limit the number of anesthesiologists in the area, but, more importantly, it reduces the incentive for improving or initiating techniques or procedures. Quality if lowered by this restraint while at the same time the hospital's profit, as demonstrated above, is raised. In the instant case, there was also testimony that the profit motive caused the hospital to hire nurse anesthetists in place of needed anesthesiologists, a practice which dilutes the professional coverage available. Secondly, the tie eliminates the surgeon or patient's choice of

> anesthesiologist at this hospital. Since one goal of antitrust law is to allow the consumer to make buying decisions without being subject to economic coercion, this anticompetitive effect is significant in a market where location tends to govern the choice of hospital.

686 F.2d at 291-92 (footnotes omitted).

ARGUMENT

A. The Decision Of The Court Of Appeals Is Supported By Prior Decisions Of This Court.

On several occasions over the past eight years this Court has declined to exempt restraints on competition among professionals from the normal rules (including the per se rule) governing Sherman Act illegality. In seeking review in this case, the petitioners implicitly ask the Court to reconsider a number of its prior decisions that support the decision of the court of appeals, including *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 95 S.Ct. 2004 (1975); *National Society of Professional Engineers v. United States*, 435 U.S. 679, 98 S.Ct. 1355 (1978); and *Arizona v. Maricopa County Medical Society*, __ U.S. __, 102 S.Ct. 2466 (1982). Unless the Court is inclined to reconsider these decisions, there is no reason to grant review in this case.

In *Goldfarb v. Virginia State Bar, supra*, the Court held that a bar association's minimum fee schedule constituted unlawful price fixing under the Sherman Act. In so holding, the Court rejected the argument that the "learned professions" are exempt from the Sherman Act prohibition. However, in a footnote, the Court suggested that the public service aspect of a profession might be rele-

vant to a Sherman Act analysis. 421 U.S. at 788, 95 S.Ct. at 2013 n. 17. Thus, *Goldfarb* apparently left open the question whether the professions, although subject to the Sherman Act, might be treated more leniently than other commercial enterprises.[1]

The door left open by *Goldfarb* was shut by the Court's decisions in *National Society of Professional Engineers v. United States, supra,* and *Arizona v. Maricopa County Medical Society, supra.* In both cases, the Court rejected arguments that restraints on professional competition should be given special consideration under the Sherman Act. In both cases, the Court applied the antitrust rules applicable to all commercial enterprises. The petitioners now complain because the court of appeals did the same in this case.

In the *Professional Engineers* case, the Court held invalid under the Sherman Act a trade association's ban on competitive bidding among professional engineers. In so holding, the Court summarily rejected the argument that the bidding ban was justified because it "ultimately inures to the public benefit by preventing the production of inferior work and by insuring ethical behavior." 435 U.S. at 693-94, 98 S.Ct. at 1366. The Court held that, *even under the Rule of Reason,* a restraint on competition can be upheld only on one ground: that the restraint in fact *promotes* competition. The Court described the standard as follows:

> The test prescribed in *Standard Oil* is whether the challenged contracts or acts "were unrea-

[1] The district court in fact relied upon *Goldfarb's* footnote 17 as the basis for its conclusion that the exclusive contract should not be judged under a per se rule. 513 F.Supp. at 543.

> sonably restrictive of competitive conditions." Unreasonableness under that test could be based either (1) on the nature or character of the contracts, or (2) on surrounding circumstances giving rise to the inference or presumption that they were intended to restrain trade and enhance prices. Under either branch of the test, the inquiry is confined to a consideration of impact on competitive conditions.
>
> * * *
>
> There are, thus, two complementary categories of antitrust analysis. In the first category are agreements whose nature and necessary effect are so plainly anticompetitive that no elaborate study of the industry is needed to establish their illegality—they are "illegal *per se*." In the second category are agreements whose competitive effect can only be evaluated by analyzing the facts peculiar to the business, the history of the restraint, and the reasons why it was imposed. *In either event, the purpose of the analysis is to form a judgment about the competitive significance of the restraint; it is not to decide whether a policy favoring competition is in the public interest, or in the interest of the members of an industry.* Subject to exceptions defined by statute, that policy decision has been made by the Congress.

Id. at 690-92, 98 S.Ct. at 1364-65 (footnotes omitted, emphasis added).

In the *Maricopa County* case, the Court held a maximum-fee agreement among doctors to be illegal per se under Section 1 of the Sherman Act. In so holding, the Court rejected the defendants' arguments that the rule of per se illegality should not be applied because: (1) the restraint involved doctors rather than nonprofessionals, (2)

the judiciary had little experience in the health care industry, and (3) the restraint was alleged to have procompetitive effects. In response to the third argument, the Court said:

> The argument indicates a misunderstanding of the *per se* concept. The anticompetitive potential inherent in all price fixing agreements justifies their facial invalidation even if procompetitive justifications are offered for some. Those claims of enhanced competition are so unlikely to prove significant in any particular case that we adhere to the rule of law that is justified in its general application. Even when the respondents are given every benefit of the doubt, the limited record in this case is not inconsistent with the presumption that the respondents' agreements will not significantly enhance competition.

__ U.S. at __, 102 S.Ct. at 2477.

These principles are controlling in this case as well. The petitioners in this case *do not even contend* that the exclusive anesthesiology contract promoted competition.[2] Rather, the petitioners have contended only that the exclusive contract resulted in certain "benefits" that allowed the Hospital's department of anesthesiology to run more efficiently. The court of appeals summarized the petitioners' contentions concerning these "benefits" as follows:

> Appellees aver that the system employed is in the best interest of quality patient care. The monitoring of specialized equipment and supervision of

[2] Nor do the petitioners seriously dispute that the exclusive contract results in the substantial restraints on competition described by the court of appeals. 686 F.2d at 291-92.

> nurses can best be handled, in their estimation, by the closed group policy. This closed group policy also gives the hospital the continuous twenty-four hour a day coverage that is crucial in the event of an emergency. Other arguments made to justify the policy are that it facilitates the use of operating rooms since no waiting for outside anesthesiologists is necessary and that it wisely allows the responsibility for development and management of the department to be placed upon one individual with legal obligations to the hospital. Finally, the appellees assert that the closed group policy permits them to more closely monitor the professional standards employed by the department members.

686 F.2d at 288 (footnote omitted).

All of these "benefits" might well be desirable;[3] *but they cannot justify a restraint on competition.* Even under the more lenient Rule of Reason, the petitioners could justify their restraint on competition only by showing that the exclusive contract somehow *promoted competition;* yet they have not even alleged that to be the case. Therefore, the exclusive contract in this case could not be upheld even under the Rule of Reason. Under the rule of per se illegality, which *presumes* that the anticompetitive effects outweigh any procompetitive justification, the result must be the same.

The decision of the court of appeals in this case is consistent with and supported by the applicable decisions of this Court. It makes no difference which test is applied. This exclusive anesthesiology contract is illegal because it

[3] In fact, the court of appeals found all of these "benefits" to be illusory in that the evidence demonstrated they could be achieved in the absence of an exclusive contract. 686 F.2d at 288 n. 2, 298.

restrains competition without legal justification. Therefore, the Court need not grant review on certiorari in this case.

B. The Traditional Reasons For Granting Review On Certiorari Are Not Present In This Case.

Rule 17 of this Court indicates the character of the reasons that the Court will consider in determining whether to grant review on certiorari. None of the reasons described in Rule 17 are present in this case.

First, there is no conflict among the circuits with respect to the issue decided by the court of appeals. Although the petitioners cite in their petition several cases decided by other circuits and imply that a conflict exists, none of these other circuit court decisions in fact even considered whether an exclusive anesthesiology contract might constitute a per se illegal tying arrangement. For example, *Capili v. Shott*, 620 F.2d 438 (4th Cir. 1980) and *Harron v. United Hospital Center, Inc.*, 522 F.2d 1133 (4th Cir. 1975), cert. denied, 424 U.S. 916, 96 S.Ct. 1116 (1976), were decided on jurisdictional grounds, not on the merits. *Dos Santos v. Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346 (7th Cir. 1982), merely reversed the granting of a preliminary injunction on the ground that irreparable harm was not shown. In *Robinson v. Magovern*, 521 F.Supp. 842 (W.D.Pa. 1981), *aff'd mem.*, 688 F.2d 824 (3rd Cir. 1982) (the only decision on the merits cited by the petitioners), there was no claim made that an exclusive anesthesiology contract constituted a per se illegal tying arrangement. There simply is no conflict among the circuits with respect to the issue of this case.

Second, this is not a case in which the court of ap-

peals "has decided an important question of federal law which has not been, but should be, settled by this Court, or has decided a federal question in a way in conflict with applicable decisions of this Court." The decision of the court of appeals is entirely consistent with the applicable decision of this Court. Furthermore, as the petitioners conceded in the lower courts,[4] the result in this case, whatever it may be, is dependent on the facts peculiar to this case. Contrary to the petitioners' current argument, this case will not, indeed cannot, govern all exclusive contracts in all specialties at all hospitals. The court of appeals merely held that, under the facts of this case, the exclusive anesthesiology contract between the Hospital and Roux & Associates constitutes an illegal tying arrangement. Other exclusive contracts employed under other circumstances must be judged on their own facts.

Under the general standards of Rule 17, this case is not worthy of review on certiorari. Therefore the petition should be denied.

C. The Petitioners Have Not Raised Any Arguments That Would Justify Review On Certiorari.

In addition to the unsupported contention that the decision of the court of appeals "sweeps aside" all exclusive contracts, the petitioners raise two other arguments. First, they claim that the exclusive contract does not create a tying arrangement at all. Second, they argue that, in any event, the tying arrangement cannot be

[4] For example, in their Memorandum in Support of Motion to Dismiss Appeal filed in the court of appeals, the petitioners stated: "This case was tried on its own particular facts and any holding herein should, in all probability, have application only with respect to this plaintiff and this defendant."

unlawful without a showing that it resulted in increased prices. Neither of these contentions has merit.

Perhaps the only point on which the district court and the court of appeals agreed was that the exclusive anesthesiology contract did create a tying arrangement. Based upon the petitioners' own evidence, the district court found that the provision of surgical facilities and the provision of anesthesiology services are separate "products" tied to each other. The district court stated:

> The provision of anesthesia services is a medical service separate from the other services provided by the hospital. The hospital charges the patient a separate charge for this service.

513 F.Supp. at 540.

The petitioners did not even challenge this finding in the court of appeals. Now, for the first time, they contend that the provision of anesthesiology services merely is one part of the overall "package" of services furnished by the Hospital. Petition at 13. The fallacy of this contention is that it ignores the distinction between the Hospital and the physicians who practice in it. Under Louisiana law, a hospital legally cannot engage in the practice of medicine (including the specialty of anesthesiology). Only the physicians who practice within the hospital are licensed to practice medicine. Therefore, it is the members of Roux & Associates, not the Hospital, who render anesthesiology services to patients; and the rendering of professional anesthesiology services cannot be characterized as merely a part of "hospital care."

If the provisions of anesthesiology services could be

so characterized, the Hospital would be guilty of violating at least two provisions of Louisiana law. In his complaint, Dr. Hyde alleged that the exclusive contract also was illegal under Louisiana law because it called (1) for "fee splitting" in violation of La. R.S. 37:1284, and (2) for the exercise of professional medical discretion by the Hospital in referring patients to Roux & Associates in violation of La. R.S. 37:1270. In other words, Dr. Hyde alleged what the petitioners' argue now, *i.e.*, that the Hospital actually was practicing medicine by providing professional anesthesiology services to patients. The district court, however, disagreed. It stated:

> The Court also finds that the portion of the anesthesia fees retained by the hospital bears a reasonable relationship to *the services and materials provided by the hospital in connection with the anesthesiology services.*
>
> The Court finds that the hospital did not improperly engage in the diagnosis and treatment of patients. *The evidence shows that the anesthesia services are provided by the anesthesiologist* who prescribes the drugs used and performs all procedures requiring expertise. The CRNA's work under the supervision of the anesthesiologists and their function is to monitor the patients while they are anesthetized.

513 F.Supp. at 539-40 (emphasis supplied).

Thus, the district court found that the provision of anesthesiology services is *not* merely a part of the overall "package" of hospital services. Rather, it is a professional service rendered by licensed anesthesiologists who are legally responsible for the anesthesiology care received by the patient. As the district court noted, the Hospital fur-

nishes only materials and the non-professional services of nurse anesthetists "in connection with" the work of the anesthesiologists. Both the district court and the court of appeals found that the provision by the Hospital of surgical facilities and the provision by Roux & Associates of anesthesiology services are separate and distinct products that are tied together by the exclusive anesthesiology contract. The petitioners' argument to the contrary lacks any evidentiary or legal basis.

The petitioners' contention that their tying arrangement with Roux & Associates cannot be held unlawful without a showing that it has resulted in a price increase also is without basis. In *Arizona v. Maricopa County Medical Society, supra*, this Court rejected a similar argument in support of an agreement to fix maximum prices. The Court said:

> In this case the rule is violated by a price restraint that tends to provide the same economic rewards to all practitioners regardless of their skill, their experience, their training, or their willingness to employ innovative and difficult procedures in individual cases. Such a restraint also may discourage entry into the market, and may deter experimentation and new developments by individual entrepreneurs. It may be a masquerade for an agreement to fix uniform prices, or it may in the future take on that character.

__ U.S. at __, 102 S.Ct. at 2475.

The anticompetition effects of the Hospital's exclusive anesthesiology contract are similar to those described by the Court in the *Maricopa County* case. The contract raises entry barriers and stifles innovation. The

court of appeals described the anticompetitive effects of the exclusive anesthesiology contract as follows:

> The exclusive contract spawns a number of anticompetitive effects. First, the tie prevents anesthesiologists from entering that part of the anesthesia services market which the hospital controls. This prohibition of competition not only serves indirectly to artificially limit the number of anesthesiologists in the area, but, more importantly, it reduces the incentive for improving or initiating techniques or procedures. Quality is lowered by this restraint while at the same time the hospital's profit, as demonstrated above, is raised. In the instant case, there was also testimony that the profit motive caused the hospital to hire more anesthetists in place of needed anesthesiologists, a practice which dilutes the professional coverage available. Secondly, the tie eliminates the surgeon's or patient's choice of anesthesiologist at the hospital. Since one goal of antitrust law is to allow the consumer to make buying decisions without being subject to economic coercion, this anticompetitive effect is significant in a market where location tends to govern the choice of hospital.

686 F.2d at 291-92 (footnotes omitted).

Based on the undisputed evidence, the court of appeals could only conclude that the tying arrangement between the Hospital and Roux & Associates substantially restrains competition among anesthesiologists. The fact that no direct price increase was shown does not save the contract from Sherman Act illegality.

CONCLUSION

The decision of the court of appeals is consistent with and supported by prior decisions of this Court. There are no compelling reasons for the Court to grant review on certiorari. Accordingly, the petition should be denied.

Respectfully submitted,

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CERTIFICATE

I certify that three copies of the foregoing brief have been mailed, postage prepaid, to counsel for the petitioners, Frank H. Easterbrook, 1111 East 60th Street, Chicago, Illinois 60637, Lucas J. Giordano, 810 Union Street, New Orleans, Louisiana 70112, and Thomas J. Reed and Henry S. Allen, Jr., 134 South LaSalle Street, Chicago, Illinois 60603, this _____ day of February, 1983.

_____

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2
and EAST JEFFERSON HOSPITAL BOARD,
Petitioners,

v.

EDWIN G. HYDE,
Respondent.

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE; BRIEF AMICUS CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether an arrangement by which a hospital chooses only one group of physicians to render all anesthesia services at the hospital is a *per se* illegal tying arrangement under Section 1 of the Sherman Act, 15 U. S. C. § 1 (1976).

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No. 82-1031

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2
and EAST JEFFERSON HOSPITAL BOARD,
Petitioners,

v.

EDWIN G. HYDE,
Respondent.

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

The American Hospital Association respectfully moves for leave to file the attached brief *amicus curiae* in support of the Petitioners' request that a writ of certiorari issue to the United States Court of Appeals for the Fifth Circuit. The consent of counsel for the Petitioners to the filing of a brief *amicus curiae* by the American Hospital Association has been obtained. The consent of counsel for the Respondent has been requested but refused.

The interest of the American Hospital Association in this matter arises from its being the primary organization of hospitals in the United States. Its membership includes approximately 6,300 hospitals and other health care institutions, a large number of which nationwide provide anesthesiology services to their patients pursuant to an exclusive arrangement with physicians of the type under scrutiny in this case. As the national

spokesman for the hospital industry, the American Hospital Association is in a unique position to represent the interests of hospitals throughout the United States which are not parties to this action but whose interests will be affected directly by the ultimate resolution of the issue presented herein and whose vital professional staffing decisions are and will remain subject to considerable uncertainty unless this Honorable Court resolves the current conflict among the decisions of the United States Courts of Appeals.

Respectfully submitted,

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v.

EDWIN G. HYDE,
Respondent.

BRIEF AMICUS CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF THE PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

INTEREST OF THE AMERICAN HOSPITAL ASSOCIATION

Amicus Curiae American Hospital Association respectfully presents this brief in support of the Petitioners' request that a writ of certiorari issue from this Court to review the judgment of the United States Court of Appeals for the Fifth Circuit in the above-entitled matter.

The American Hospital Association ("AHA") is the primary organization of hospitals in the United States. It is a not-for-profit membership corporation organized under the laws of the State of Illinois. The principal corporate objective of the AHA is "to promote the welfare of the public through its leadership and its assistance to its members in the provision of

better health services for all people." The AHA has a federal income tax exemption under the provisions of Section 501(c)(6) of the Internal Revenue Code. Its membership includes approximately 6,300 hospitals and other health care institutions, as well as approximately 35,000 individuals.

The AHA has an historical commitment to the principle of quality health care for hospital patients, while recognizing that the containment of hospital costs is vital to the continued provision of that quality care by hospitals. Hence, the AHA traditionally has undertaken to assist its members in their efforts to achieve the delivery of cost-effective, high quality health care services. Because a hospital itself obviously is not a practitioner of medicine, its relationships with physicians are of critical importance to its success in achieving that goal, and to the ability of the hospital's governing board to discharge its own ultimate responsibility — imposed by federal Medicare program participation requirements, by voluntary accreditation standards, and, increasingly, by common law — for the composition and services of its medical staff.

The AHA recognizes that good medical care is being provided in hospitals by physicians under many different types of staffing arrangements and does not recommend or endorse any specific arrangement as the best means in all circumstances to provide hospital or medical services. *See* American Hospital Association, *Guidelines: Contractual Relationships Between Hospitals and Physicians* (1976). However, many of AHA's member hospitals, in the exercise of their professional judgment, maintain exclusive arrangements with physicians as a means to ensure twenty-four hour physician availability for provision of the subject service, to monitor most effectively the quality of health care services provided, to secure administrative services necessary to the most effective and efficient provision of the subject service, to enhance their ability to attract highly skilled physicians to their staffs, and to lower operating costs and thus to help restrain the rate of increase of

hospital costs. Such arrangements are particularly prevalent with respect to the provision of necessary, "ancillary" hospital services—anesthesiology, radiology, pathology and emergency room services—for the availability and quality of which hospitals bear an independent and judicially-recognized accountability to their patients. The AHA further believes that an exclusive arrangement of the type at issue in this case not only can serve the above-described important interests of the hospital and the community, and confer significant benefits on patients, but also actually serves to foster rather than inhibit competition in the health care marketplace. Consequently, the AHA strongly supports the right of hospitals to maintain the flexibility to enter into an exclusive arrangement with a physician or physician group if the hospital determines that such a staffing arrangement best allows it to serve the interests of its patients.

This brief is submitted in the hope that it will assist the Court in deciding to issue a writ of certiorari in this case and to rule on the important issue presented herein.

SUMMARY OF THE ARGUMENT

Amicus Curiae AHA respectfully submits that the Petitioners' request that this Court issue a writ of certiorari to the United States Court of Appeals for the Fifth Circuit should be granted for several reasons. First, the decision below creates a conflict among the United States Courts of Appeals with respect to both the lawfulness of exclusive arrangements under the antitrust laws and the appropriate standard of analysis, the Rule of Reason or the *per se* rule, to be applied. Second, the analysis of the Fifth Circuit's decision directly calls into question the validity of exclusive arrangements for the provision of medical services in addition to anesthesia. It thus creates profound uncertainty for numerous hospitals with respect to use of a staffing arrangement which can be critical to their ability to provide cost-effective, quality patient care. Third, the decision below conflicts with previous decisions of this Court with respect to the circumstances in which the *per se* standard of analysis should apply. Fourth, the Fifth Circuit erred in finding that the arrangement at issue is a tying arrangement, in that only one product—surgical services—actually is being sold. Finally, because the hospital lacked sufficient market power in the purported tying service to "leverage" itself in the tied service market, the Fifth Circuit erred in finding a *per se* violation of Section 1 of the Sherman Act.

REASONS FOR GRANTING THE PETITION

I. Conflict Among the Circuits

The United States Court of Appeals for the Fifth Circuit held that the exclusive arrangement at issue herein establishes a tying arrangement *per se* violative of Section 1 of the Sherman Act. 686 F. 2d 286 (5th Cir. 1982). The decision below thus made *per se* illegal what the district court found is a "common practice in the health care industry for hospitals to enter into exclusive contracts with physicians. . . ." 513 F. Supp. 532, 540

(E.D. La. 1981). *See also Dos Santos* v. *Columbus-Cuneo-Cabrini Medical Center,* 684 F. 2d 1346, 1351 (7th Cir. 1982) ("exclusive dealing arrangement[s] ... [have] been adopted by most hospitals in the Chicago area").

It is particularly noteworthy, however, that every other federal court which has considered an exclusive arrangement has analyzed it under the Rule of Reason, and no federal court other than the Fifth Circuit in the instant case has found a violation of the Sherman Act. Those courts also have rejected all previous attempts to attach the *per se* label to an arrangement consistently found reasonable after appropriate analysis of its effects. *See Dos Santos,* 684 F. 2d at 1352 (rejecting argument that exclusive arrangement shown to constitute group boycott or other *per se* violation); *Smith* v. *Northern Michigan Hospitals, Inc.,* 518 F. Supp. 644 (W. D. Mich. 1981) (awarding summary judgment for defendant-hospital in action challenging exclusive contract for staffing of emergency room as, *inter alia,* refusal to deal). *See also Valley Hospital Medical Center Foundation* v. *Adolph,* No. 79-3336 MRP (C. D. Cal. Mar. 2, 1981).

With respect specifically to the several United States Courts of Appeals, the decision below has created a conflict among the decisions of the Fourth, Fifth and Seventh Circuits as to both the lawfulness of such arrangements and the analysis to be applied in judging their validity.

In *Harron* v. *United Hospital Center, Inc.,* 522 F. 2d 1133 (4th Cir. 1975), *cert. denied,* 424 U. S. 916 (1976), the Fourth Circuit considered a challenge under Section 1 of the Sherman Act to the hospital's exclusive contractual arrangement with an individual physician for the provision of all radiology services at the hospital. On appeal, the court of appeals found the plaintiff's Section 1 challenge to be "frivolous," reversed the district court's granting of a preliminary injunction against the hospital, and remanded the case with instructions that the

district court dismiss the complaint "for want of a substantial federal question and a consequent lack of jurisdiction." *Id.* at 1134. *See also Capili* v. *Shott,* 487 F. Supp. 710 (S. D. W. Va. 1978), *aff'd,* 620 F. 2d 438 (4th Cir. 1980) (challenge to exclusive arrangement for provision of anesthesia services failed to show effect on interstate commerce; arrangement also was neither unreasonable nor arbitrary).

The Seventh Circuit Court of Appeals, in *Dos Santos* v. *Columbus-Cuneo-Cabrini Medical Center,* 684 F. 2d 1346 (7th Cir. 1982), vacated a preliminary injunction entered in favor of a plaintiff-physician who had challenged under Section 1 of the Sherman Act an exclusive contractual arrangement for the provision of anesthesia services. Most significantly, the court of appeals rejected an argument that the exclusive arrangement amounted to a group boycott or other *per se* violation, concluding instead that the case was "properly treated . . . as one involving a vertical combination . . . [which] . . . must be analyzed under the Rule of Reason." *Id.* at 1352, *citing, e.g., Tampa Electric Co.* v. *Nashville Coal Co.,* 365 U. S. 320 (1961).

Further, in concluding that it had "serious question whether plaintiff . . . demonstrated a reasonable likelihood of success on the merits," the Seventh Circuit adopted for purposes of its analysis the reasoning of the *district* court in the instant case, noting with "particular interest" that court's conclusion as to the relevant geographic market and its findings concerning the procompetitive effects of exclusive contracts. 684 F. 2d at 1353-54. Finally, the Seventh Circuit specifically instructed that the district court at trial should consider whether—in light of the fact, *inter alia,* that the patient generally takes no part in the selection of a particular anesthesiologist, that the expense to the patient of anesthesia services ordinarily is at least partially insured or otherwise payable by a third party, and that the hospital itself bears a legal responsibility for the availability and quality of anesthesia services rendered—it may be more

appropriate for antitrust purposes to treat the *hospital* rather than the patient as the purchaser of anesthesia services. *Id.* at 1354. Treatment of the hospital as the purchaser of the services would make impossible a finding that the exclusive arrangement at issue herein establishes a tying arrangement.

Thus, decisions of the Fourth and, in particular, the Seventh Circuit Courts of Appeals stand in stark contrast to that of the Fifth Circuit below and demonstrate as well that, with respect to exclusive arrangements for the provision of medical services, the nature of certain crucial economic relationships, assumed by the Fifth Circuit, remains far from clear.

Finally, it must be observed that the analysis of the Fifth Circuit below conflicts with decisions of the Third and Sixth Circuits, which, although involving staffing arrangements not exclusive in nature, raised similar antitrust issues, and in which Rule of Reason analysis was deemed appropriate. *See Stella* v. *Mercy Hospital,* No. 82-1274 (6th Cir. Oct. 25, 1982); *Robinson* v. *Magovern,* 521 F. Supp. 842 (W. D. Pa. 1981), *aff'd mem.,* 688 F. 2d 824 (3d Cir.), *cert. denied,* 103 S. Ct. 302 (1982). *See also Pontius* v. *Children's Hospital,* No. 78-987 (W. D. Pa. Dec. 20, 1982); *Pao* v. *Holy Redeemer Hospital,* 547 F. Supp. 484 (E. D. Pa. 1982).

II. Importance of the Issue Within the Hospital Field

a. In General

As recognized by courts that have considered exclusive arrangements of the type at issue herein, the use of such arrangements is widespread within the hospital field. *E.g., Dos Santos,* 684 F. 2d at 1351. Their increasing prevalence reflects both growing specialization and increasing sophistication in the delivery of medical services, as well as the ability of the arrangements to address important needs with respect to the delivery of such services. Specifically, exclusive arrangements allow hospitals to secure and maintain continuously available,

high quality medical services, to secure administrative services necessary to the effective and efficient operation of the subject department, and to lower the hospital's operating costs.

Hospitals today utilize contractual arrangements, many exclusive in nature, to ensure the provision of an increasing number of medical specialty services including, among others, nuclear medicine, renal dialysis and cardiac catheterization. However, the use of exclusive arrangements is especially prevalent nationwide with respect to the provision of hospital-based ancillary services —anesthesiology, radiology, pathology and emergency room services. As their name implies, ancillary services are provided in support of the primary service for which the patient is in the hospital. For example, anesthesia is one of the many services that are essential but 'ancillary' to the provision of the surgical services for which the patient has been admitted, and thus is viewed by most patients as part of the "hospitalization package." Patients in fact do not choose the ancillary care physicians who will provide those necessary services. *See Dos Santos,* 684 F. 2d at 1354; *United States* v. *American Society of Anesthesiologists,* 473 F. Supp. 147, 160 (S.D.N.Y. 1979)("there is unrefuted evidence that the patient is not truly a customer of the anesthesiologist"). Instead, they rely upon others—e.g., their individual surgeons and, ultimately, the hospital itself—both to make informed choices of ancillary care physicians for them, and, in effect, to vouch for the quality of the services provided.

The necessary nature of the ancillary services, combined with the lack of physician selection by the patient, has led courts to recognize the special legal obligation of the hospital to ensure the availability and quality of those services. *E.g., Dos Santos,* 684 F. 2d at 1354; *Capili,* 487 F. Supp. at 712 ("[t]hese are the services a hospital must guarantee as available to all patients . . . [;] [b]ecause the hospital patients do not select the physicians rendering these services and generally

do not even know the names or qualifications of these physicians, the hospital has a greater burden of responsibility in assuring the proper quality and quantity of such services"). *See also* HHS Medicare Conditions of Participation, 42 C.F.R. § 405.1011 *et seq.* (1977); Joint Commission on Accreditation of Hospitals ("JCAH"), *Accreditation Manual for Hospitals* (1982), for specific requirements imposed on hospitals for the provision of ancillary medical services.

b. Quality and Efficiency Benefits

Many hospitals have determined that, in light of their own individual circumstances and experiences, exclusive arrangements provide the most effective and often the *only* means to ensure both the continuous availability of medical services and the quality of those services. One essential characteristic of exclusive arrangements between hospitals and physicians is precisely that the physicians contractually guarantee the hospital twenty-four hour coverage of the subject service in return for the exclusive right to provide all such services at the hospital. Indeed, hospitals may find that they are unable to attract to their staffs anesthesiologists and other ancillary care physicians who are able to guarantee continuously available care unless those physicians are granted the exclusive right to provide all of the subject services at the hospital. Physicians cannot feasibly provide assurances of coverage or quality where departmental responsibilities are fragmented.

In the absence of a contractual guarantee of continuous coverage, a hospital is likely to experience situations where anesthesiologists, e.g., are unavailable for surgery either because of sickness, vacation, or time limitations. *See Capili*, 487 F. Supp. at 711, 712 (prior to contracting exclusively, hospital attempted to ensure coverage through "on call" services of anesthesiologists, which proved "inadequate to insure proper patient care"; JCAH annual review of hospital under "on call" arrangement indicated "deficiencies" in provision of anesthesia services). As specifically found by the district court in the

instant case, an exclusive arrangement assures the hospital twenty-four hour coverage of the subject service, 513 F. Supp. at 540; *see also, e.g., Dos Santos,* 684 F. 2d at 1351; *Capili,* 487 F. Supp. at 712, and thus assists the hospital both to ensure proper patient care and to avoid potential liability based on inadequate rendition of that care.

In addition, courts (including the district court below), commentators and hospitals have recognized that exclusive arrangements produce numerous other, specific patient care and efficiency-related benefits which may be unattainable except by use of an exclusive arrangement but which also are crucial to the hospital's ability to discharge its own responsibilities concerning the quality and availability of medical services. *See generally* M.R. Pollard & R.F. Leibenluft, *Antitrust and the Health Professions; Policy Planning Issues Paper* (Federal Trade Commission, 1981) [hereinafter cited as Pollard & Leibenluft]; Foster, *Exclusive Arrangements Between Hospitals and Physicians: Antitrust's Next Frontier in Health?,* 26 St. Louis U. L. J. 535 (1982) [hereinafter cited as Foster]. In general, those benefits flow from the exclusive contract's specific provision for the unified responsibility and accountability of a limited number of physicians to the hospital's governing board for the quality of all services rendered, as well as the physicians' typical contractual responsibility for the complete management of the hospital department, including the provision of supervisory, training and administrative services essential to the most effective and efficient delivery of the subject service.

Among the many benefits resulting from an exclusive arrangement between a hospital and a physician group is the hospital's increased ability to monitor continuously the performance of the contracting physicians to ensure that medical quality standards are being met. *See, e.g.,* Pollard & Leibenluft, *supra,* at 97; Foster, *supra.* Also, the exclusive arrange-

ment serves to foster greater physician competence, due to increased specialization with attendant development of skills through repetition of specialized procedures. *Id.*

In addition, because the terms of exclusive arrangements typically are for short periods of time and/or terminable on short notice, a hospital dissatisfied with the performance of the contracting physicians can terminate the arrangement and contract with others. *Cf. Dos Santos,* 684 F.2d at 1354 (exclusive arrangements "may also serve to benefit competition among anesthesiology groups[,] ... encourag[ing] anesthesiologists to improve the quality of their services in order to obtain these contracts") (quoting the *district* court herein, 513 F. Supp. at 541); *Smith,* 518 F. Supp. 644 (rejecting physician group's antitrust challenge to exclusive contract, which was awarded to second group determined by hospital to be better qualified).

Further, caselaw emphasizes that exclusive arrangements facilitate improved scheduling in the use of facilities and support staff. *E.g., Capili,* 487 F. Supp. at 712 ("advantages of the exclusive arrangement [for provision of anesthesia services] ... included the efficient scheduling of surgery"). Procedures are done best, most reliably and most efficiently when access to facilities and equipment is planned in advance. Such planning typically is one of the specific contractual obligations of the physician group, and is simplified when coordinated through a single source. For example, a hospital that maintains an exclusive arrangement with an anesthesiology group secures thereby unified responsibility for the scheduling of use of the operating room, effectively minimizing the delays and conflicts that arise when a hospital must accommodate the personal scheduling wishes of multiple independent practitioners.

Exclusive arrangements also provide greater control and standardization of procedures, thereby allowing lower opera-

ting costs. *See, e.g., Smith,* 518 F. Supp. at 648 ("exclusive contract permits more control over standards, personnel and procedures"). More effective selection, use and maintenance of equipment also results. *See, e.g., Capili,* 487 F. Supp. at 712 ("advantages of the exclusive arrangement . . . included . . . the uniform selection and use of anesthesia equipment and gasses"). For example, the use of costly and sophisticated equipment by only one group minimizes the number of equipment breakdowns and facilitates recognition and remedy of malfunctions that do occur. Further, an exclusive arrangement directly facilitates improved work routines and teamwork because physicians both work consistently with and have a specific contractual obligation to supervise a particular group of nurses and technicians, whose services also are crucial to the effective and efficient delivery of the subject service. *See generally* Pollard & Leibenluft, *supra,* at 97; Foster, *supra.*

Finally, then, and as a result of the many benefits discussed above, the hospital is able to earn an enhanced reputation for excellence, thus enabling it to attract top flight physicians. *Id.* Given the increased willingness of courts to hold hospitals liable for negligently granting staff privileges to unqualified physicians, *see, e.g., Elam* v. *College Park Hospital,* 183 Cal. Rptr. 156 (Cal. App. 1982), this consideration is particularly important if the hospital is to minimize its vulnerability to malpractice litigation. In addition, however, the ability of the hospital to compete also is enhanced given that hospitals traditionally have competed on a non-price basis to provide the best *quality* of patient care. *E.g., Robinson,* 521 F. Supp. at 919 (closed staff system may promote competition among hospitals resulting in improved quality of patient care). *See Dos Santos,* 684 F. 2d at 1354 ("competition among the hospitals in the market [may be enhanced] by increasing the quality of medical care available") (quoting the decision of the *district* court herein, 513 F. Supp. at 541).

Thus, it is apparent that a hospital has a strong independent interest in maintaining exclusive arrangements with physicians. Demonstrable benefits obtained by the use of such arrangements directly assist the hospital to discharge its legal and professional obligation to its patients to ensure continuously available, high quality health care, and assist it to compete effectively with other hospitals.

III. The Decision of the Fifth Circuit Below, Applying the *Per Se* Standard of Antitrust Analysis to a Non-Price, Vertical Arrangement, Conflicts With Prior Decisions of This Court Which Prescribe the Circumstances Under Which Use of the *Per Se* Rule Is Appropriate.

a. In *Continental T.V., Inc.* v. *GTE Sylvania, Inc.*, 433 U. S. 36 (1977), this Court explained that "[*p*]*er se* rules of illegality are appropriate only when they relate to conduct that is manifestly anticompetitive." *Id.* at 50. Recognizing that non-price, vertical restraints often have substantial redeeming virtues, such as the promotion of efficiency, protection from products liability claims and increased competition among firms at the manufacturing level, this Court held that, while it was possible that some vertical restraints might deserve *per se* treatment, any "departure from the rule of reason standard must be based upon demonstrable economic effect rather than . . . upon formalistic line drawing." *Id.* at 58-59.

The economic impact of the hospital's arrangement is similar to that presented in *Sylvania*, and has similar redeeming virtues. To increase the efficiency of providing medical services and to increase the quality of those services (for which the hospital bears legal responsibility), the hospital established what was, in effect, an exclusive distributorship for anesthesiology services which, when combined with other inputs, produced surgical procedures. By improperly delineating the hospital's relevant geographic market (see *infra*) to determine whether the hospital had sufficient economic power to justify *per se* analysis, and then by improperly invoking the *per se* rule, the

Fifth Circuit could not weigh properly the procompetitive effects of the hospital's arrangement against any purported anticompetitive effects. Rather, it engaged in the "formalistic line drawing" against which this Court has warned.

b. In *Broadcast Music, Inc.* v. *Columbia Broadcasting System,* 441 U. S. 1 (1979), this Court again discussed those circumstances in which a *per se* analysis is proper. Emphasizing that the crucial consideration is the conduct's impact on competition rather than its label, this Court held that the practice challenged there did not appear to be a "naked restrain[t] of trade with no purpose except stifling of competition," *id.* at 20 (quoting *White Motor Co.* v. *United States,* 372 U. S. 253, 263 (1963)), and thus that the *per se* rule did not apply. This Court explained that *per se* analysis is proper only where the practice "appears to be one that would always or almost always tend to restrict competition and decrease output," 441 U. S. at 19-20, rather than where the arrangement is "designed to increase economic efficiency and render markets more rather than less competitive." *Id.* (quoting *United States* v. *United States Gypsum Co.,* 438 U. S. 422, 441 n.16 (1978)).

The Fifth Circuit's error was in mechanically applying the tying label to the arrangement in question and then applying the *per se* rule. Had the court below first properly undertaken a threshold examination of the arrangement's economic effect, it would have found no restriction on the output of anesthesiology services because, as it held, the arrangement "did not lead to a higher charge for anesthesia services." 686 F. 2d at 291. Indeed, it is ironic that, according to the court below, the hospital violated the antitrust laws by an arrangement that both lowered costs and increased efficiency at the hospital, enhancing its status as an effective competitor.

c. Contrary to the position taken by the Fifth Circuit below, this Court's recent decision in *Arizona* v. *Maricopa County Medical Society,* 102 S. Ct. 2466 (1982), does not

mandate *per se* analysis here, even if the exclusive arrangement were viewed as a tying arrangement. That case focused on a horizontal agreement involving price. Non-price, vertical arrangements, in which the hospital has no incentive to undermine competition among physicians with whom it is not in competition, can generate significant procompetitive benefits that require consideration under a Rule of Reason standard.

Here, unlike in *Maricopa County*, the petitioner argues that its conduct beneficially affects the quality of service rendered at the hospital and thus the degree of competition in the market. Because the focus of competition among hospitals is on quality rather than price, *see, e.g., Robinson* v. *Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981), actions by the hospital which can increase quality are particularly important and serve a competitive purpose.

The Fifth Circuit's holding that *Maricopa County* requires that certain non-price restraints be judged under the *per se* rule also conflicts directly with the Fourth Circuit's decision in *Hospital Building Co.* v. *Trustees of Rex Hospital*, 691 F. 2d 678 (4th Cir. 1982). There, the Fourth Circuit specifically distinguished between price and non-price restraints and refused to apply the *per se* rule to conduct which a jury had found to constitute a group boycott and market division. *Id.* at 684 n. 3. Thus, the instant case provides an excellent opportunity for this Court to clarify the scope of its *Maricopa County* decision.

IV. The Fifth Circuit Erred in Viewing the Facts of This Case as Constituting a Tying Arrangement

The Fifth Circuit below concluded without discussion that the instant case "deal[s] with two distinct services which a buyer should be able to obtain separately"—specifically, operating room and anesthesia services. 686 F. 2d at 289. However, operating rooms and anesthesia services cannot realistically be viewed as distinct and independently useful to the

patient, the availability of the latter being critical to the provision of the former. A patient admitted to a hospital for surgery depends upon the hospital and his or her individual surgeon to ensure the availability of anesthesia as well as numerous other services (e.g., anatomical pathology, blood room and various standby services) without which surgical procedures simply will not be performed in any modern hospital. Thus, only one product—surgical services—actually is being sold, and in selecting the anesthesiologist the hospital simply acts as a joint purchasing agent for its patients. Numerous decisions reject the Fifth Circuit's approach of defining a tying arrangement by looking for potentially severable components of what actually is a single service. *See, e.g., Times-Picayune Publishing Co.* v. *United States,* 345 U. S. 594 (1953).

V. The Fifth Circuit Erred in Finding a *Per Se* Violation, Relying on Erroneous Economic Analysis.

The tying characterization, as demonstrated above, is manifestly inappropriate to the economic arrangement in question. Moreover, the Fifth Circuit's holding that the arrangement is *per se* unlawful is erroneous because the hospital lacks appreciable economic power in an appropriately-defined relevant geographic market.

a. This Court has recognized many times that the major adverse economic impact from tying arrangements "is the wielding of monopolistic leverage; a seller exploits his dominant position in one market to expand his empire into the next." *Times-Picayune,* 345 U. S. at 611. *See also Fortner Enterprises, Inc.* v. *United States Steel Corp.,* 394 U. S. 495, 512 (1969) (White, J., dissenting). Use of leverage to expand market power in the tied product market is what distinguishes an unlawful tying arrangement from a legitimate exclusive dealing agreement and thus is the only factor that even arguably justifies a *per se* rather than a Rule of Reason analysis. On the other hand, "[i]f the product in the second market would be accepted anyway, because of its own merit, then, of course, no

leverage is involved." *Ungar* v. *Dunkin' Donuts of America, Inc.*, 531 F. 2d 1211, 1218 (3d Cir.), *cert. denied*, 429 U. S. 923 (1976).

b. In the instant case, the hospital did not engage in leveraging and in fact could not have done so. First, there is no indication in the record that patients objected to purchasing as a package the hospital's service and that of the anesthesiologist chosen by the hospital. This strongly suggests that no leverage was involved. Second, if the arrangement did not increase the price of anesthesiology services, as the Fifth Circuit held, output was not restricted and leverage was not exercised. *See generally* Bowman, *Tying Arrangements and the Leverage Problem*, 67 Yale L. J. 19, 20 (1957).

Perhaps most importantly, however, the hospital clearly lacked the "appreciable economic power" in the market for the purported tying service, *United States Steel Corp.* v. *Fortner Enterprises, Inc.*, 429 U. S. 610, 611-12 (1977), necessary to engage in leveraging and thus coerce patients into accepting both its service and that of the anesthesiologists chosen by it. As this Court stated in *Northern Pacific Railway Co.* v. *United States*, 356 U. S. 1, 6 (1958), proof of this power is crucial:

> [W]here the seller has no control or dominance over the tying product so that it does not represent an effectual weapon to pressure buyers into taking the tied item, any restraint of trade attributable to such tying arrangements would obviously be insignificant at most.

c. The crucial question in determining whether a seller has sufficient power in the market for the tying service to raise prices or coerce buyers into accepting other burdensome terms is "whether the seller has some advantage not shared by his competitors in the market for the tying product." *United States Steel Corp.* v. *Fortner Enterprises, Inc.*, 429 U. S. 610, 620 (1977). The Fifth Circuit erroneously circumvented this question by improperly rejecting the district court's finding that the geographic market included at least the East Banks of

Jefferson and Orleans Parishes and concluding that the market was only the East Bank of Jefferson Parish. Even then, however, the court did not assess whether the hospital had some peculiar or unique advantage over others in the improperly defined market.

In delineating the geographic market, the court below erred in several significant respects. First, it assumed that the hospital industry is so different from others that all purchasers buy from the closest supplier. If this were true, every hospital would be a monopoly and competition among hospitals would be nonexistent—a suggestion totally divorced from reality. In reality, the primary influences on where a patient is hospitalized are the quality of care the facility offers and the facility suggested by the patient's physician, who is knowledgeable about that quality.

Most importantly, what little evidence there was with respect to geographic market showed that the proper relevant market is substantially larger than the East Bank of Jefferson Parish. The court's reliance on Louisiana law directing the hospital to provide care in the hospital district was misplaced because the statute provides no constraint to deter either East Jefferson residents from using other hospitals in New Orleans or residents from other areas of New Orleans from using East Jefferson Hospital. Moreover, as the Fifth Circuit explained, only thirty percent of patients from the court's purported market, the East Jefferson Area, used East Jefferson Hospital. Fully seventy percent used other hospitals in the metropolitan New Orleans area. It is highly likely, therefore, that an overwhelming number of East Jefferson residents are hospitalized in facilities outside of the East Jefferson Area. Those hospitals clearly would constrain East Jefferson Hospital's behavior, and the geographic market must include them and the areas that they serve. Of course, these hospitals would become even more attractive to patients residing in the East Jefferson Area if East Jefferson Hospital or the anesthesiology

group practicing there attempted to lower quality or raise prices.

The Fifth Circuit's opinion fails even to suggest East Jefferson Hospital's share of a properly defined market. If, however, as the Fifth Circuit agreed, there are twenty other hospitals in the area, that share must be extremely small; certainly it would be insufficient to permit leveraging by East Jefferson Hospital unless the hospital had some unique competitive advantage, a factor which the Fifth Circuit did not discuss.

d. The court below clearly erred in assessing the hospital's economic power and thus its ability to impose a tying arrangement. More importantly, its analysis of the relevant geographic market for hospital services conflicts with that of other courts examining the same issue. *See, e.g., Robinson* v. *Magovern,* 521 F. Supp. 842, 878-86 (W. D. Pa. 1981), *aff'd mem.,* 688 F. 2d 824 (3d Cir.), *cert. denied,* 103 S. Ct. 302 (1982). As the health care industry in general and hospitals in particular are subjected to increasing antitrust scrutiny, proper market delineation is crucial and deserves examination and clarification by this Court.

CONCLUSION

The economic environment of health care is changing through public and private policy initiatives. The direction of these changes is such that increased application of antitrust law to health care may be anticipated. Those in the health field believe that well-reasoned application of the law is imperative to avoid needless and harmful disruption of critical patient care arrangements. To this end, we respectfully request that this Court issue the writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit.

Respectfully submitted,

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82-1031

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1982

No. 82-

JEFFERSON PARISH HOSPITAL
DISTRICT NO. 2 and
EAST JEFFERSON HOSPITAL BOARD,
Petitioners,

versus

EDWIN C. HYDE,
Respondent.

BRIEF AMICUS CURIAE OF LOUISIANA HOSPITAL ASSOCIATION IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE AND BRIEF AMICUS CURIAE

The Louisiana Hospital Association respectfully moves for leave to file the attached brief *amicus curiae* in support of petitioner's request for a writ of certiorari to the United States Court of Appeals for the Fifth Circuit. The consent of the attorney for the petitioner has been obtained. The consent of the attorney for the respondent has been requested but refused.

The interest of the Louisiana Hospital Association in this case arises from the fact that it is a trade organization of Louisiana hospitals whose members are affected by the decision of the appellate court in this case. The Louisiana Hospital Association is in a unique position to represent the interests of the hospitals in Louisiana which are not parties to this action but who will be affected by the eventual outcome of this case. Furthermore, many of our member hospitals are units of multi-hospital systems operating in several states and will be subject to conflicting decisions by the United States Courts of Appeal unless this issue is decided by this Honorable Court.

Respectfully submitted,

Ricardo M. Guevara
Counsel for the Louisiana Hospital Association

CERTIFICATE OF SERVICE

I hereby certify that I have this _____ day of January, 1983 served copies of the foregoing motion and the attached Brief *Amicus Curiae* of the Louisiana Hospital Association by sending three copies thereof by first class mail, postage prepaid, to each of the following:

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IN THE

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INTEREST OF THE AMICUS CURIAE

The Louisiana Hospital Association is a trade organization composed of one hundred thirty six (136) hospitals. The Louisiana Hospital Association is the largest organization representing the interests of hospitals in Louisiana. The member

hospitals cover the spectrum of the hospital industry in Louisiana. The Association has as members small and rural hospitals with as few as twenty-one (21) beds and two physicians on their medical staffs as well as major urban tertiary care and teaching hospitals with over six hundred (600) beds and hundreds of physicians on their medical staffs. The needs of these institutions vary greatly. The small and rural hospital may not have enough demand for anesthesia services to support more than one anesthesiologist and the only way the hospital can attract that anesthesiologist is by granting him an exclusive contract. The entire medical staff of the large teaching hospital may be employees of the hospital and perform both teaching and clinical tasks as part of their duties and to open the anesthesia staff to private fee for service non-teaching physicians would be disruptive of the institution's primary goal — the education of student physicians, nurses and other health care providers. The Association's members are nonprofit community hospitals, others are nonprofit hospitals owned by religious orders, others are university-owned teaching hospitals, some are hospital service district hospitals created by the parishes and are political subdivisions of the State of Louisiana, some are federally owned and operated and others are investor-owned for-profit hospitals.

The Association's members are ever cognizant of their obligation to provide high quality medical care to their patients in an economic and efficient manner. The governing boards of member hospitals recognize that they are ultimately responsible for the quality of the medical care rendered in their institutions.

The Louisiana Hospital Association and its members are

vitally concerned in this case because its outcome will affect the manner in which hospitals fulfill their obligations to their patients. The use of exclusive anesthesia contracts is a widely used method of guaranteeing twenty-four hour anesthesiologist availability. *Dos Santos v. Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346, 1351 (7th Cir. 1982). However, such exclusive contracts are not universal. Some member hospitals have open anesthesia staff. What is of utmost importance to the Louisiana Hospital Association is that its member hospitals have the flexibility to be as innovative as legally possible in meeting the unique needs of their patients. If this means using an exclusive contract to provide anesthesiologist coverage then our hospitals should be allowed to so contract. If it means maintaining an open anesthesia staff then the hospitals should have that option as well.

Lastly, many of our hospitals are components of multi-hospital systems which operate nationwide. The investor-owned hospital chains own and operate hospitals not only in Louisiana but in several other states, so do many of the religious orders. These organizations are now faced with conflicting judicial decisions by the United States Courts of Appeals. The United States Court of Appeals for the Seventh Circuit has held an exclusive anesthesia contract not to be violative of the Sherman Act. See *Dos Santos v. Columbus-Cuneo-Cabrini Medical Center* (ibid). The United States Court of Appeals for the Fifth Circuit has ruled in the instant case that an exclusive anesthesia contract is a per se violation of the Sherman Act. Therefore, the investor owned and religious owned multi-hospital systems may use exclusive contracts in one area of the country but not in the states of Texas, Louisiana and Mississippi. Whether an exclusive an-

esthesia contract is a violation of the Sherman Act should not be determined on the basis of where the contract was perfected.

It is for these reasons that the Louisiana Hospital Association supports the position of Jefferson Parish Hospital District No. 2 and East Jefferson Hospital Board and supports the petition for a Writ of Certiorari to United States Court of Appeals for the Fifth Circuit.

SUMMARY OF REASONS FOR GRANTING PETITION

It is respectfully suggested that petitioner's request for a writ of certiorari should be granted because the appellate court's ruling results in a conflict in the circuits on this issue. Furthermore, the appellate court's ruling in this case calls into question the legality of exclusive contracts with other physician specialists such as pathologists and radiologists. Lastly, the appellate court's ruling results in an inconsistent application of the per se analysis.

REASONS FOR GRANTING PETITION

The issue presented is whether an exclusive contract, which provides a hospital with the services of a select group of anesthesiologists to provide for the anesthesia needs of the hospital's patients on a twenty-four-hour-a-day-seven-days-a-week basis, is a per se violation of the Sherman Act, 15 U.S.C. subsection 1.

The trial court, the Federal District Court for the Eastern District of Louisiana, held not only that such a contract was

not a per se violation of the Sherman Act but that it satisfied the rule of reason analysis, 513 F. Supp. 539 (1981) at 543. On appeal the United States Court of Appeals for the Fifth Circuit held that arrangement in question was a per se violation of the Sherman Act, 686 F. 2d 286 (1982) at 293.

We believe petitioner's request for a writ of certiorari should be granted because the court of appeals holding does several things. First it creates a conflict in the circuits on this issue. (See *Dos Santos v. Columbus-Cuneo-Cabrini Medical Center*, 684 F. 2d 1346 (7th Cir. 1982). Secondly, in holding that a hospital's exclusive contract for the provision of anesthesia services is per se illegal the appellate court has cast doubt as to the legality of the hospital's exclusive contracts for the provision of other services such as radiology, pathology, cardiology and others. Furthermore, the appellate court's ruling cannot be logically limited to contracts providing for the availability of physician services only. The appellate court's holding jeopardizes the method by which the hospital provides a myriad of services to its patients. Under the appellate court's ruling a hospital could legitimately provide the patient with only one service that being a hospital bed. All the other services which hospitals presently provide would be engaging in tying arrangements. This is so because the provision of the other services (the tied services) would be conditioned upon the patient's use of a hospital bed (the tying service). Therefore, the patient would have to obtain his own nursing services, his own food services, his own respiratory therapy services, his own physical therapy services and so on. All of these services, which hospitals currently provide as a standard course, would have to be obtained by the patient from other sources. This is not how modern hospitals

operate nor is it likely that they could operate under such a scheme. Hospitals are not merely hotels for ill and injured where physicians and other health care practitioners, operating as independent contractors, provide services to the patients. Rather, for the most part, the hospital itself provides these services through its employees or agents. The major exception to this is the provision of services by the patient's attending physician and consulting physicians. The hospital does not sell and the patient does not purchase several products but rather the hospital sells and the patient purchases one product — competent high quality hospital care — which is composed of several integral components such as nursing service, food service and anesthesia services.

Thirdly, the appellate court's decision leaves hospitals and the health industry in a quagmire. On the one hand the appellate court indicates that there is nothing so unique about the health care industry as to preclude the application of traditional per se analyses 686 F.2d 286 (1982) at 293 and on the other hand the appellate court indicates that the trial court erred in applying the traditional method of economic analysis for determining market power because it "assumes that the health care industry functions as a competitve market in the same sense as the industries involved in the plethora of other tying cases and should be subject to the same standards. This is not correct. Several market imperfections in the health care industry favor public not for profit entities, like East Jefferson Hospital." 686 F. 2d 286 (1982) at 291. It seems incongruous that the imperfections of the health care industry are insufficient to preclude per se analysis but are sufficient to allow the use of non-traditional economic analysis for the determination of market power under the per se rule.

CONCLUSION

Petitioner, Jefferson Parish Hospital District No. 2 and the East Jefferson Hospital Boards, petition for a writ of certiorari to the United States Court of Appeals should be granted because the appellate court's ruling creates a conflict in the circuits, seriously jeopardizes the legality of how hospitals provide services to their patients, and results in an inconsistent application of the per se analysis.

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OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 and EAST JEFFERSON HOSPITAL BOARD, PETITIONERS

v.

EDWIN G. HYDE

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether a contract for a single group of anesthesiologists to provide exclusive anesthesia services to a hospital is per se illegal under the Sherman Act as a "tie-in" of surgical and anesthesia services.

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In the Supreme Court of the United States

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No. 82-1031

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 and EAST JEFFERSON HOSPITAL BOARD, PETITIONERS

v.

EDWIN G. HYDE

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

INTEREST OF THE UNITED STATES

The United States and the Federal Trade Commission, which have primary responsibility for enforcement of the federal antitrust laws, have a substantial interest in assuring that the Sherman Act is construed in a manner that advances the Act's objective of protecting the nation's competitive economic system.

STATEMENT

1. Petitioner Jefferson Parish Hospital District No. 2 (District) owns East Jefferson District Hospital (East Jefferson or Hospital) (Pet. App. 20a). The Hospital is located in Metairie, Louisiana, a suburb of New Orleans. Prior to opening in 1971, the Hospital entered into a contract with Roux & Associates (Roux), a professional medical corporation, for Roux to be the exclusive

provider of anesthesia services for the Hospital. *Id.* at 22a. In 1976, the contract was renewed, and Roux continues to provide all anesthesia services at the Hospital. *Id.* at 23a.[1]

Respondent, Dr. Edwin Hyde, is a licensed and board certified anesthesiologist who chairs the anesthesiology department at Lakeside Hospital in New Orleans. *Id.* at 2a, 30a. When he applied for staff privileges at East Jefferson the Hospital's Credentials Committee recommended that Hyde be appointed to the staff, but the Board of Directors refused him privileges because of the exclusive contract with Roux. *Id.* at 25a-26a.

Hyde brought this antitrust suit in the United States District Court for the Eastern District of Louisiana, claiming that the Hospital had tied the use of the Roux's anesthesia services to purchase of the Hospital's surgical facilities and that this conduct violated Section 1 of the Sherman Act, 15 U.S.C. 1. Pet. App. 36a-37a.[2]

2. The district court dismissed the complaint. Although it assumed there was a "tie" of two separate services,[3] the district court rejected respondents' claim of per se illegality. First, the court held that the professions are not subject to the same per se rules applicable to other businesses. *Id.* at 37a, 40a. It also ruled that the tie was not illegal per se since the Hospital did not have dominant power in the market for surgical facilities, the tying product. *Id.* at 38a. This ruling rested on its finding that the geographic market in-

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[1] At Roux's request the contract language designating Roux as the exclusive provider of anesthesia services was deleted in 1976; the Hospital, however, has maintained its practice of relying exclusively on Roux for these services. Pet. App. 23a.

[2] Respondent also alleged violations of the Fourteenth Amendment and of state law. The district court dismissed those claims. Pet. App. 42a-47a. The court of appeals did not reach the issues (Pet. App. 5a n.3), and they are not before this Court.

[3] The only finding on this issue was that the anesthesia service appears as a separate item on the patient's bill. Pet. App. 33a.

cluded at least 20 other hospitals that provided the same surgical services. *Id.* at 34a. These hospitals serve the large majority of East Jefferson residents; indeed, 70% of patients who live in East Jefferson Parish go to hospitals other than East Jefferson. *Id.* at 33a. The court also found that traditional indicia of market power were lacking: the tying product was not unique; the Hospital's prices were no higher than its competitors' nor were its terms of supply more burdensome; and there was no indication that unwilling patients were coerced to take a product on unsatisfactory terms. *Id.* at 37a-38a.[4]

The district court therefore applied the rule of reason to petitioners' conduct and found it reasonable. It noted significant efficiencies that resulted from the exclusive contract with Roux: improved round-the-clock coverage, better control and standardization of procedures, and more efficient and less costly operation of the department.[5] And it concluded that, given the relevant market,

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[4] The district court found that most surgeons have privileges at more than one hospital; thus, they can take their patients to another hospital if they want to choose a particular anesthesiologist. Pet. App. at 34a. Patients have the same choice. *Ibid.*

The court also found that it is common practice in the health care industry for hospitals to enter into exclusive contracts with physicians engaged in certain hospital-based specialties, such as anesthesiology, radiology and pathology, to insure the availability of these services to their patients; and that, generally, a patient does not specifically select a particular specialist to perform these services. *Id.* at 32a. In the court's view, these factors increased the hospital's responsibility to provide quality service. *Ibid.*

[5] The court found that such a system lends flexibility to the scheduling of operations because it is not necessary to accommodate physicians with outside commitments; it permits the doctors, nurses, and technicians in the department to develop a work routine and a proficiency with the equipment; it increases the Hospital's ability to monitor performance because fewer individuals are involved; and maintenance of equipment is simplified and equipment breakdowns reduced by being limited to use by fewer doctors. Pet. App. at 32a-33a.

the benefits of the closed system outweighed any "minimal" foreclosure effects.

3. The court of appeals reversed. Pet. App. 1a-19a. It concluded that the Hospital's contract with Roux was illegal per se.[6] *Id.* at 14a-15a. In reaching this conclusion, the court stated that there was a "tie" of "two distinct services which a buyer should be able to obtain separately," *i.e.*, surgical services and anesthesia. *Id.* at 5a-6a. Next, the court rejected the district court's finding that the proper geographic market was East Jefferson Parish because, in its view, imperfections in the health market (due to third-party payors, and inability of patients to compare the quality of medical care) deprive consumers of the incentive to shop for quality or lower costs; consumers are therefore likely to select the hospital closest to their homes. *Id.* at 9a. The court thus found the relevant market to be the East Bank of Jefferson Parish, a market "much smaller than the district court found," and one in which the Hospital "ha[s] sufficient market power * * * to coerce purchase of the tied product." *Id.* at 10a. The court's finding of market power was based on the fact that one-third of the patients from the East Bank of East Jefferson go to the Hospital. *Ibid.*

Addressing the anticompetitive effects of the challenged practice,[7] the court acknowledged that the "tie-in" did not result in higher charges for anesthesia services. Pet. App. 11a. It found, however, that "it accomplished just as dramatic an effect by increasing the hospital's profit" by enabling the Hospital to "supplement[] a small contract group of anesthesiologists with a much larger group of lower priced [paraprofessional] anesthesists." *Id.* at 11a-

[6] The court held that per se rules under the Sherman Act are applicable to the health care industry as to other industries. Pet. App. at 14a-18a. See *Arizona* v. *Maricopa County Medical Society*, No. 80-419 (June 18, 1982).

[7] It was apparently not disputed that the practice involved a "not insubstantial" volume of interstate commerce, and the district court had so found. Pet. App. 32a.

12a. The court found that the contract produced "a number of anticompetitive effects": it prevents anesthesiologists from entering the portion of the market controlled by the Hospital; it indirectly limits the number of anesthesiologists in the area, and reduces the incentive for improving quality; and it limits the surgeon's or patient's choice of anesthesiologist. *Id.* at 12a. In addition, the court rejected the contention that competition still exists at the point where the contract for anesthesiology is awarded by the Hospital, because the Hospital "has not permitted this competition since the original contract was signed over ten years ago." *Id.* at 12a n.9. The court also rejected the Hospital's "business justifications" for the contracts because, in the court's view, the same objectives could be achieved through less restrictive alternatives. *Id.* at 14a.

DISCUSSION

The United States believes that this case is appropriate for review by this Court. By applying a per se rule of illegality to a common practice, the decision below conflicts with the decisions of every other court of appeals that has considered antitrust challenges to exclusive arrangements between hospitals and physicians. In our view, the court erred in regarding the anesthesia service contract as a tying agreement rather than as an exclusive dealing contract. This error merits correction for it creates a clear conflict between the Fifth Circuit and other courts of appeals. We believe, in addition, that the court of appeals' opinion is badly flawed in its analysis.

1. The court of appeals' decision conflicts with every other circuit court decision that has considered antitrust challenges to exclusive arrangements between hospitals and physicians. Each of the other courts has treated the challenged exclusive arrangement as a vertical restriction subject to the rule of reason.[8] Like the district court

[8] *Dos Santos* v. *Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346 (7th Cir. 1982); *Capili* v. *Shott*, 620 F.2d 438 (4th Cir. 1980); *Harron* v. *United Hospital Center, Inc.*, 522 F.2d 1133 (4th Cir. 1975), cert. denied, 424 U.S. 916 (1976); *Smith* v. *Northern Michi-*

here, these courts have found that such exclusive contracts do not necessarily have anticompetitive effects and have concluded that the particular arrangement at issue in each case did not unreasonably restrain trade. Moreover, some of the courts have specifically noted that exclusive contracts and similar arrangements may increase competition among hospitals and among physician groups. *Dos Santos, supra*, 684 F.2d at 1353-1354; *Robinson* v. *Magovern*, 521 F. Supp. 842, aff'd mem., 688 F.2d 824 (3d Cir. 1982), cert. denied, No. 82-415 (Nov. 1, 1982).

A general medical and surgical hospital, such as East Jefferson, holds itself out as having facilities and services available for general surgery and it competes for the business of patients who require such medical care. It must therefore provide the proper operating room and equipment, and must also assure that anesthesia services are available as needed. The hospital can assure the availability of such services in a number of ways, including "opening" its staff to any competent anesthesiologist, entering an exclusive contract with a particular group, or hiring anesthesiologists directly as employees. The East Jefferson Hospital decided to fulfill its obligation to have anesthesia services available by entering into the challenged exclusive contract with the Roux group. From this perspective, the contract is clearly a form of partial vertical integration analogous to requirements contracts, which are used by buyers to obtain an assured source of supply. It is apparent, therefore, that the arrangement is not a naked attempt to restrain trade warranting condemnation under a per se rule. Indeed, as recognized by the district court below and by the Seventh Circuit in *Dos Santos*, such contracts may enhance competition among hospitals and among anesthesiologists. See pages 10-12, 16, *infra*. Thus, the challenged practice should be judged under the

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gan Hospitals, Inc., 518 F. Supp. 644 (W.D. Mich. 1981), appeal pending, No. 81-1513 (6th Cir. argued Oct. 21, 1982). See also *Robinson* v. *Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981), aff'd mem., 688 F.2d 824 (3d Cir. 1982), cert. denied, No. 82-415 (Nov. 1, 1982).

rule of reason, rather than a per se standard, because—like any requirements contract—it "may well be of economic advantage * * * to the consuming public." *Standard Oil Co.* v. *United States*, 337 U.S. 293, 305-306 (1949).[9]

2. a. The court of appeals gave two reasons in support of its finding that a tying arrangement exists in this case: (1) users of the Hospital's operating rooms are "compelled to purchase the hospital's chosen anesthesia service"; and (2) "we are dealing with two distinct services which a buyer should be able to obtain separately." Pet. App. 5a-6a. Its cursory analysis, amounting to a "separability" test, led the court to ignore both the close functional relationship between the allegedly tied services, and the vertical integration achieved by the challenged contract. The court therefore mischaracterized the arrangement, and applied a per se test of illegality, in contrast to other courts (see note 8, *supra*) that have properly considered similar hospital practices to be exclusive dealing arrangements subject to the rule of reason.

As this Court made clear in the first case to present the "tie-in" characterization issue, the mere separability of combined products or services does not suffice for invocation of the tying doctrine. *Times-Picayune Publishing Co.* v. *United States*, 345 U.S. 594 (1953). Looking beyond mere separability, the opinion in *Times-Picayune* assessed the nature and function of the allegedly tied products and the realities of the market. *Id.* at 613. It then compared the challenged practice with the "common core of the adjudicated unlawful tying [cases]"—"the forced purchase of a second distinct commodity * * * resulting in economic harm to competition in the 'tied' market." *Id.* at 614. Finding that "neither the rationale nor the doc-

[9] Like other types of vertical agreements, exclusive dealing contracts are illegal only if they have unreasonably anticompetitive effects that are not outweighed by their procompetitive effects. See *Tampa Electric Co.* v. *Nashville Coal Co.*, 365 U.S. 320, 327 (1961); *Twin City Sportservice, Inc.* v. *Charles O. Finley & Co.*, 676 F.2d 1291 (9th Cir. 1982), cert. denied, No. 82-396 (Nov. 8, 1982).

trines evolved by the 'tying' cases" were involved, the Court refused to dispose of the case under the tying rule; it held instead that the challenged practice must be "tested under the Sherman Act's general prohibition on unreasonable restraints of trade." *Ibid.*

Likewise, most lower courts have looked beyond the separability of products sold as a package in deciding whether to treat an aggregation as a "tie"; they have instead looked to the seller's reasons for coupling the products and the policies underlying the tying rule as guides to characterization.[10] In contrast to the oversimplified approach adopted by the Fifth Circuit, the better reasoned opinions have "long recognized that the rules governing tying arrangements are designed to strike solely at practices employed to impede competition on the merits." *Hirsh* v. *Martindale-Hubbell, Inc.*, 674 F.2d 1343, 1348 (9th Cir. 1982), cert. denied, No. 82-570 (Nov. 1, 1982). As *Hirsh* and similar cases illustrate, a conclusion that an illegal tying arrangement exists cannot properly be reached without consideration of the purposes of the tying rule and the competitive function of the challenged aggregation of products. Because the Hospital's anesthesia contract combines functionally related services in an efficient form of vertical integration, it does not create a "forced purchase of a * * * distinct commodity" and may not cause "economic harm to competition in the 'tied' market." It therefore should not be characterized as a tying arrangement. *Times-Picayune, supra*, 345 U.S. at 614.

Rather than employing the wooden characterization of the Fifth Circuit, several courts of appeals have set out general principles and practical factors that are useful in

[10] See, *e.g.*, *Krehl* v. *Baskin-Robbins Ice Cream Co.*, 664 F.2d 1348, 1354 (9th Cir. 1982); *Principe* v. *McDonald's Corp.*, 631 F.2d 303 (4th Cir. 1980), cert. denied, 451 U.S. 970 (1981); *Siegel* v. *Chicken Delight, Inc.*, 448 F.2d 43, 47 (9th Cir. 1971), cert. denied, 405 U.S. 955 (1972); *Dehydrating Process Co.* v. *A.O. Smith Corp.*, 292 F.2d 653 (1st Cir.), cert. denied, 368 U.S. 931 (1961); *United States* v. *Jerrold Electronics Corp.*, 187 F. Supp. 545 (E.D. Pa. 1969), aff'd per curiam, 365 U.S. 567 (1961).

determining "whether an aggregation of separable items should be regarded as one or more items for tie-in purposes." *Siegel* v. *Chicken Delight, Inc.*, 448 F.2d 43, 48 (9th Cir. 1971), cert. denied, 405 U.S. 955 (1972). The key is the "function of the aggregation," *Principe* v. *McDonald's Corp.*, 631 F.2d 303, 308 (4th Cir. 1980), cert. denied, 451 U.S. 970 (1981); *Krehl* v. *Baskin-Robbins Ice Cream Co.*, 664 F.2d 1348, 1352 (9th Cir. 1982), and the "relationship" between the alleged tying product (here, the hospital's operation rooms) and the alleged tied product (here, the hospital's chosen anesthesia service). *Id.* at 1353; *Hirsh* v. *Martindale-Hubbell, Inc.*, *supra*, 674 F.2d at 1347-1348. No matter how physically distinct and no matter who supplies them, combined products have not been deemed to be "tied" if their aggregation is an integral or important component of the seller's competitive strategy—if the combination reflects the defendant's strategy for competing on the merits. See, *e.g.*, *Principe*, *supra*, 631 F.2d at 309-311; *Krehl*, *supra*, 664 F.2d at 1353-1354.

Hirsh v. *Martindale-Hubbell, Inc.*, *supra*, and *Siegel* v. *Chicken Delight, Inc.*, *supra*, illustrate the appropriate analysis to employ in resolving characterization questions in tie-in cases. In *Hirsh*, the Ninth Circuit stated that it must consider "whether the aggregation serves to facilitate competition by promoting product quality or whether it, in fact, amounts to no more than a naked effort to impede competition on the merits." 674 F.2d at 1347. The court enunciated the following principle for characterizing an aggregation of products (*id.* at 1348):

> [W]here * * * the aggregate sale of ostensibly separate items serves to improve the quality of the product offered by the seller * * * no tying arrangement is present.

Under the *Hirsh* test, the challenged conduct does not constitute tying because it serves to enhance competition and efficiency in both of the vertically linked markets.

In *Siegel*, the Ninth Circuit posed three questions that help determine whether the aggregation is likely to aid or

hinder competition and whether the allegedly tied products should be deemed to be "distinct": (1) "whether the amalgamation of products resulted in cost savings apart from those reductions in sales expenses and the like normally attendant upon any tie-in"; (2) "whether the items are normally sold or used as a unit with fixed proportions"; and (3) "whether the * * * items in the aggregation are to be regarded as distinct items which can be traded in distinct markets." 448 F.2d at 48. Under the *Siegel* criteria, the decision below is erroneous.

First, both the district court (Pet. App. 24a, 27a) and the court of appeals (*id.* at 11a-12a) found that the exclusive contract resulted in significant cost savings by facilitating the use of nurse-anesthetists to perform tasks that otherwise would be performed at greater expense by anesthesiologists. This suggests that the combination can enhance efficiency and competition.[11] Second, the allegedly tied products are indeed "normally used as a unit." [12] It is important for characterization purposes

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[11] The court of appeals erred in holding that such cost savings brought about an anticompetitive result merely by increasing the Hospital's profits (Pet. App. 11a-12a). Arrangements that increase efficiency and lower costs enhance consumer welfare, even if they also increase a firm's profits. It is, of course, the profit incentive that motivates firms to innovate and to reduce costs.

The court was also incorrect in implying that anesthesiologists require special protection from nurse-anesthetists, their "paraprofessional counterpart[s]" (Pet. App. 11a). To the contrary, the antitrust laws were promulgated to promote, not frustrate, the entry of competitive alternatives. The antitrust laws should not be transformed into a tool that allows competitors to prevent competition by competent, state-licensed, non-physician health care providers; their purpose, rather, is to assure that consumers will have such state-authorized alternatives available.

[12] It surely cannot be conclusive for characterization purposes that anesthesia facilities and services may be billed separately. In *United States* v. *Jerrold Electronics Corp.*, 187 F. Supp. 545, 559 (E.D. Pa. 1960), aff'd per curiam, 365 U.S. 567 (1961), the court recognized that market factors may justify pricing components of an aggregation separately. Here, the vagaries of the health insurance system and the necessities of hospital accounting procedures

that it is a "normal" or common practice for hospitals to enter into exclusive contracts with physicians in certain specialties such as anesthesiology.[13] When an aggregation or combination of services is a common industry practice, it can be expected (absent evidence to the contrary) that the coupling serves some useful marketing or production purpose; and when many firms in an industry offer the same package of products, it can also be expected that economic power or leverage is probably not the force creating the aggregation.

Equally important in a tying analysis is the fact that hospital operating rooms and anesthesia services are traditionally, and indeed inescapably, "used as a unit with fixed proportions." Operating room patients expect—and strongly desire—to purchase anesthesia services along with the hospital room and the operation; there is no "forced purchase of a second distinct commodity," *Times-Picayune*, *supra*, 345 U.S. at 614, because the purchase of anesthesia services is neither "forced" nor "distinct".[14]

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explain separate billing. Similarly, it is not conclusive for characterization purposes that the anesthesia services are supplied by a different entity than the hospital. See *Krehl*, *supra*, 664 F.2d at 1353 n.14; *Kugler* v. *AAMCO Automatic Transmissions, Inc.*, 460 F.2d 1214 (8th Cir. 1972). By definition, every instance of partial vertical integration will involve two separate entities; that fact alone cannot turn such integration into a tying arrangement. The relevant question from an antitrust perspective is whether the function of the aggregation is to create a better product and allow the seller to compete more effectively on the merits, not whether the packaged product is produced by one or more firms.

[13] The district court found such contracts to be a "common practice" (Pet. App. 32a), and there was evidence that a majority of hospitals in the New Orleans metropolitan area have similarly closed anesthesiology departments (Pet. App. 26a). In *Dos Santos*, the Seventh Circuit noted that such arrangements are "widespread" and have "been adopted by most hospitals in the Chicago area." 684 F.2d at 1351.

[14] Cf. *Northern Pacific Ry.* v. *United States*, 356 U.S. 1, 17 (1958) (Harlan, J., dissenting) ("the inclusion of the tying clauses in contracts or leases might have been largely a matter of

Instead, anesthesia services are clearly "an ancillary and necessary part" of the total operation package. *Washington Gas Light Co.* v. *Virginia Electric & Power Co.*, 438 F.2d 248, 253-254 (4th Cir. 1971) ("*WGL*"). The patient does not want the operation without the anesthesia; the anesthesia *must* be supplied at the same time and place as the operation; the hospital *must* provide the equipment and facilities used by whoever performs the anesthesia services; and the hospital has the obligation to assure that quality anesthesia services are available as needed. In such a situation, a hospital may choose not to integrate the provision of anesthesia into the package of services, but the policies traditionally invoked in tying cases present no rationale for automatically preventing such integration. Since anesthesia is an indispensable part of the operation package, and since the Hospital does not require that the patient purchase more anesthesia than necessary, *Fortner Enterprises, Inc.* v. *United States Steel Corp.*, 394 U.S. 495, 507 (1969), operating rooms and anesthesia services "may be fairly treated by a seller as inseparable," *A.O. Smith*, *supra*, 292 F.2d at 655, and the rationale involved in the tying cases is inapplicable.

As the above discussion indicates, operating rooms and anesthesia services simply cannot be "regarded as distinct items which can be traded in distinct markets." *Siegel*, *supra*, 448 F.2d at 48. There is no separate consumer demand for anesthesia services—the demand for the two products is complementary; their markets are interdependent, not distinct. Therefore, as the Fourth Circuit said in *WGL*, *supra*, 438 F.2d at 253, where it concluded that there was no separate market for the installation of underground wiring as distinct from the market for electricity, "[t]hat there are not dual markets strongly suggests there are not separate products."

2. b. Beyond its mischaracterization of the Hospital's exclusive contract as a tying arrangement, the court of appeals used an incorrect analysis in holding that the Hos-

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indifference to at least many of the purchasers or lessees of appellants' land * * *").

pital has sufficient power in the tying market to warrant per se condemnation. The court of appeals not only failed to identify the kinds of "advantages" that would indicate the Hospital has the requisite market power, *United States Steel Corp.* v. *Fortner Enterprises, Inc.*, 429 U.S. 610, 620 (1977) ("*Fortner II*"), it has also ignored this Court's admonition that "the whole and not part of a relevant market must be assigned controlling weight" when testing the strength of a firm's tying "lever." *Times-Picayune, supra*, 345 U.S. at 611.

The court of appeals recognized that under a "traditional method of economic power analysis" the respondent "has failed to prove an illegal tying arrangement" (Pet. App. 8a). It nonetheless concluded that the Hospital has sufficient power to warrant automatic condemnation as a tie-in, because it believed that patients "select the hospital closest to home" and prefer a "non-profit entity" (Pet. App. 9a)and that the proper geographic market therefore consists solely of the East Bank of Jefferson Parish. While the proximity and profit status of a hospital may be taken into account by many patients, neither factor has been shown to be of such overwhelming importance as to convey to a hospital the requisite "advantage" over its competitors.[15]

Other courts have correctly applied the "traditional" method of economic analysis rejected by the Fifth Circuit

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[15] The court of appeals' finding of "sufficient market power" based on the Hospital's 30% market share (Pet. App. 10a), without examination of the degree of competitive advantage reflected by that market share, defeats any rational aim of using "economic power" to gauge the likelihood of anticompetitive effects. As this Court has noted, "no magic inheres in numbers; 'the relative effect of percentage command of a market varies with the setting in which that factor is placed.'" *Times-Picayune Publishing Co.* v. *United States, supra*, 345 U.S. at 612, quoting, *United States* v. *Columbia Steel Co.*, 334 U.S. 495, 528 (1948). But the decision below does not indicate that the Hospital possessed either market dominance or any distinct advantage over its competitors for offering a unique or differentiated product. See *Fortner II, supra*, 429 U.S. at 620-621.

(Pet. App. 8a) when defining a hospital's geographic market. As this Court did in *Tampa Electric, supra*, 365 U.S. at 331-333, the better reasoned decisions have attempted to "identify the area of effective competition that the defendant encounters when it offers the designated product for sale." *Magovern, supra*, 521 F. Supp. at 878; see also *United States* v. *Hospital Affiliates International, Inc.*, 1980-1 Trade Cas. (CCH) ¶ 63,721, at 77,852-77,853 (E.D. La. 1980). Had the correct market definition test been employed in this case, the more likely conclusion would have been that the geographic market extends beyond the Parish line and that East Jefferson Hospital lacks significant market power or any material advantages not shared by its competitors. As the court of appeals recognized, the contract at issue here "involved only one hospital out of at least twenty" in a geographic area that also includes New Orleans (Pet. App. 8a, 33a). Furthermore, patients and surgeons have—and frequently exercise (*ibid.*)—the "right to go to another hospital if they are at all dissatisfied with the anesthesia service offered at East Jefferson Hospital" (*id.* at 8a).

3. The court of appeals' wooden characterization of the contract as a "tie-in" and its erroneous market definitions led the court automatically to apply the per se proscription of *International Salt Co.* v. *United States*, 332 U.S. 392 (1947), and *Northern Pacific Ry.* v. *United States*, 356 U.S. 1 (1958), to what is essentially an exclusive dealing arrangement. This is not merely erroneous as a matter of law, it is ill-advised as a matter of public policy. Sellers throughout our economy offer aggregations of parts, products and services that *can* be sold separately, but that sometimes may be supplied more efficiently and conveniently when packaged together. Indeed, quality innovations and cost break-throughs often consist of new combinations of products or services that previously were sold separately. It is therefore imperative that antitrust courts continue to distinguish aggregations that promote consumer welfare and competition

through increased efficiency and quality from those that injure competition and coerce consumers.

The difference between the Fifth Circuit's analysis and that employed by all other courts that have considered the question underscores the need to recognize that the principles underlying the prohibition of pernicious tie-ins —those with anticompetitive effects—do not require the mechanical application of a per se rule to all conduct that could conceivably be labeled a "tie-in" of two products. Other courts have correctly treated such arrangements as vertical restrictions subject to scrutiny under the rule of reason. See note 8, *supra;* cf. *Continental T.V., Inc.* v. *GTE Sylvania, Inc.*, 433 U.S. 36 (1977). Like the district court in this case, these courts have found that such exclusive contracts do not necessarily have anticompetitive effects and have concluded that the particular conduct at issue did not unreasonably restrain trade. Moreover, some of the courts have specifically noted that exclusive contracts and similar arrangements may increase competition among hospitals and among physicians. *Dos Santos* v. *Columbus-Cuneo-Cabrini Medical Center, supra*, 684 F.2d at 1353-1354; *Robinson* v. *Magovern, supra*, 521 F. Supp. at 919; see *Standard Oil Co.* v. *United States*, 337 U.S. 293, 305-306 (1949).

While some arrangements that link the sales of two products or services may, of course, have anticompetitive effects, see, *e.g., Times-Picayune Publishing Co.* v. *United States*, 345 U.S. 594, 611 (1953), this is not to say that such effects need be assumed or that the combined sales of two products in one package will never have procompetitive (or potentially procompetitive) uses. Indeed, the possibility that the conduct at issue here would increase competition is amply demonstrated by the facts, and, more generally, such salutary effects have been recognized by the courts and legal commentators.

The district court found that the Hospital's contract with Roux may enhance competition among hospitals and

among anesthesiologists. See also *Dos Santos, supra*. Hospitals with exclusive contracts may be able to offer better services at lower prices and, therefore, compete more effectively for patients and physician referrals. For example, both courts below recognized (Pet. App. 11a-12a, 32a) that the contract allowed the Hospital to utilize the services of nurse-anesthetists more fully, thus lowering costs. Similarly, groups of anesthesiologists may compete for an exclusive contract (either to obtain it originally, or to keep it) by offering high quality, efficient services. Such rivalry may be more vigorous in that event than it would under the "open staff" system favored by respondent and required by the court of appeals. The system may provide greater efficiency to the Hospital, which, in this economic setting, may have a greater incentive to reduce costs than do "consumers", *i.e.*, patients, most of whom are covered by insurance and often do not discuss—or pay—medical fees.

Such efficiencies and procompetitive effects serve not only to emphasize the particular errors in the decision below, but also to illustrate the inherent risks of a rule that automatically condemns sales arrangements as illegal simply because a court employs the pejorative "tie-in" label to conduct without regard to such efficiencies and benefits. In light of the growing awareness among the courts and the commentators that not all conduct that by some stretch of the imagination could be called a "tie-in" should be presumptively banned, a standard more faithful to the principles underlying *International Salt* and *Fortner II* would recognize that such potentially procompetitive arrangements should not automatically be deemed illegal.

The legal literature and the cases have come to note the procompetitive potential of purported tie-ins. See *Fortner Enterprises, Inc.* v. *United States Steel Corp.*, 394 U.S. 495, 514 n.9 (White, J., dissenting) ("the fact that tie-ins are not entirely unmitigated evils should be borne in mind"), P. Areeda, *Antitrust Analysis* 571 (2d ed.

1974); Bowman, *Tying Arrangements and the Leverage Problem*, 67 Yale L.J. 19, 29 (1957). In his dissenting opinion in *Fortner Enterprises, Inc.* v. *United States Steel Corp.*, *supra*, 394 U.S. at 514 n.9, Justice White observed that:

> Tie-ins may also at times be beneficial to the economy. * * * They may facilitate new entry into fields where established sellers have wedded their customers to them by ties of habit and custom. *Brown Shoe Co.* v. *United States*, 370 U.S. 294, 330 (1962); Note, Newcomer Defenses: Reasonable Use of Tie-ins, Franchises, Territorials, and Exclusives, 18 Stan. L. Rev. 457 (1966). They may permit clandestine price cutting in products which otherwise would have no price competition at all because of fear of retaliation from the few other producers dealing in the market. They may protect the reputation of the tying product if failure to use the tied product in conjunction with it may cause it to misfunction. Compare *International Business Machines Corp.* v. *United States*, 298 U.S. 131, 138-140 (1936), and *Standard Oil Co.* v. *United States*, 337 U.S. 293, 306 (1949), with *Pick Mfg. Co.* v. *General Motors Corp.*, 80 F.2d 641 (C.A. 7th Cir. 1935), aff'd, 299 U.S. 3 (1936). And, if the tied and tying products are functionally related, they may reduce costs through economies of joint production and distribution. * * *

Illustrations abound to demonstrate potential benefits similar to those Justice White noted. For example, no one would seriously contend that the sale of a right shoe with the sale of a left shoe is an illegal "tie-in." This is because the cost efficiencies in such a sale are implicitly acknowledged. R. Bork, *The Antitrust Paradox* 378-379 (1978); see also Turner, *The Validity of Tying Arrangements Under the Antitrust Laws*, 72 Harv. L. Rev. 50, 71-72 (1958) (proper product definition is "not bounded by the minimum product that could or is typically sold, but rather bounds at the point where the amalgamation appears to have little economic justification"); E. Singer,

Antitrust Economics and Legal Analysis 106 (1981) ("Economies of production through tying arrangements include almost all assembled products. A radio, for example, is theoretically a tying arrangement of semiconductors and resistors. However, the functional necessity for all parts excludes the radio from the tying arrangements nomenclature.").

In appropriate circumstances, one recognized justification for such arrangements is to protect the seller's goodwill by assuring that the tying product is used with essential complements that do not impair the product's quality or performance. *United States* v. *Jerrold Electronics Corp.*, 187 F. Supp. 545, 559 (E.D. Pa. 1960), aff'd per curiam, 365 U.S. 567 (1961); see also *Pick Manufacturing Co.* v. *General Motors Corp.*, 80 F.2d 641, 643 (7th Cir. 1935), aff'd per curiam, 299 U.S. 3 (1936). Moreover, it has been suggested that such packaged sales may be used to meter intensity of demand for the tying good through a complementary "tied" item (*e.g.*, a stapling machine and staples), so the seller can price the "tying" product in direct proportion to its use. See O. Williamson, *Markets and Hierarchies: Analysis and Antitrust Implications* 11-13 (1975); R. Bork, *The Antitrust Paradox*, *supra*, at 375-376. Cf. *IBM* v. *United States*, 298 U.S. 131 (1936); *International Salt Co.* v. *United States*, *supra*; *Henry* v. *A.B. Dick Co.*, 224 U.S. 1 (1912). This can increase output of the "tying" product.

In light of some of these potential procompetitive functions, the courts have applied the per se standard to alleged tie-ins in a manner that takes into account the competitive effects of the conduct at issue. Thus, as discussed above, a sale must be found to involve two separate and distinct products or services before it will automatically be condemned. *Times-Picayune Publishing Co.* v. *United States*, *supra*, 345 U.S. at 614. When sensitively applied, this one-product/two-product distinction can serve to avoid automatic proscription of efficient sales arrangements. See Baker, *The Supreme Court and the*

Per Se Tying Rule: Cutting the Gordian Knot, 66 Va. L. Rev. 1235, 1315 (1980).[16]

Courts have also used the other pre-conditions of a tie-in—that the seller have sufficient economic power in the market for the tying product and that a "not insubstantial" amount of commerce in the tied market be affected—to avoid the mechanical condemnation of sales arrangements whose purpose and effect are not likely to be anticompetitive. See *United States Steel Corp.* v. *Fortner Enterprises, Inc.*, 429 U.S. 610 (1977); *Warner Management Consultants, Inc.* v. *Data General Corp.*, 545 F. Supp. 956, 965-966 (N.D. Ill. 1982); *In re Data General Corp. Antitrust Litigation*, 529 F. Supp. 801, 806-821 (N.D. Cal. 1981); *JBL Enterprises, Inc.* v. *Jhirmack Enterprises, Inc.*, 509 F. Supp. 357, 377-378 (N.D. Cal. 1981); *Refrigeration Engineering Corp.* v. *Frick Co.*, 370 F. Supp. 702, 711-712 (W.D. Tex. 1974).

In contrast to the better-reasoned decisions of courts that have recognized that economic efficiencies may be achieved through purported tie-ins, the court below

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[16] For example, in *United States* v. *Jerrold Electronic Corp.*, *supra*, 187 F. Supp. at 559-560, the court accepted "a sound business reason" (*i.e.*, the need to launch and develop a new experimental business using sensitive and unstable equipment) as a legal justification for treating the sale of a package of various items of equipment designed for community antenna systems as the sale of a "single product." Accord, *Dehydrating Process Co.* v. *A.O. Smith Corp.*, 292 F.2d 653, 655-656 (1st Cir.), cert. denied, 368 U.S. 931 (1961) ("sound business interests of seller" warranted treatment of components as "inseparable"); *Foster* v. *Maryland State Savings & Loan Ass'n*, 590 F.2d 928, 932 (D.C. Cir. 1978), cert. denied, 439 U.S. 1071 (1979) ("Incidental services purchased by the seller * * * for legitimate business reasons cannot be viewed as a separate (or tied) product, merely because the buyer is charged for them"); see also *Hirsh* v. *Martindale-Hubbell, Inc.*, *supra*, 674 F.2d at 1347 (sale is a "single" product where the aggregation serves to facilitate competition by promoting product quality); cf. *Siegel* v. *Chicken Delight, Inc.*, 448 F.2d 43, 48 (9th Cir. 1971), cert. denied, 405 U.S. 955 (1972) (package may be single product where the amalgamation results in cost savings apart from reduction in sales expenses and the like, or where the items are normally sold or used in fixed proportions).

eschewed any such analysis and instead found it "clear that we are dealing with two distinct services which a buyer should be able to obtain separately." Pet. App. 5a-6a. The court's failure even to consider the possible efficiencies and advantages to the Hospital and consumers[17] serves to emphasize the inherent problems of a wooden application of the per se rule.[18] While we are troubled by the court of appeals' failure to appreciate the potential efficiencies of the conduct at issue, we do not suggest that the appropriate legal standard requires comprehensive inquiry in every case into all the potential benefits of a combination sale or that if a practice did not produce efficiencies in a particular case it should be condemned as per se unlawful. On the contrary, the quality of analysis is likely to be improved and clearer guidance provided if analysis is focused on the limited

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[17] While the court of appeals did discuss what it viewed as anticompetitive aspects of the contract arrangement (Pet. App. 12a-13a), this discussion was directly keyed to its erroneously restrictive market definition and therefore failed to address the anticompetitive impact issues in the proper context.

[18] The error of this approach was exacerbated by the court's invocation of a "less restrictive" alternative standard (Pet. App. 13a-14a). While the clear availability of such alternatives may be a relevant factor in determining the existence of either anticompetitive intent or effect (see *White Motor Co.* v. *United States*, 372 U.S. 253, 270-272 (1963) (Brennan, J., concurring); *Berkey Photo, Inc.* v. *Eastman Kodak Co.*, 603 F.2d 263, 303 (2d Cir. 1979), cert. denied, 444 U.S. 1093 (1980)), the existence of such an alternative does not in itself prove that the means selected were either unreasonable or anticompetitive. The rule employed by the court below would, in the words of the Third Circuit (*American Motor Inns, Inc.* v. *Holiday Inns, Inc.*, 521 F.2d 1230, 1249-1250 (1975)), make firms "guarantors that the imaginations of lawyers could not conjure up some method of achieving the business purpose in question that would result in a somewhat lesser restriction of trade. And courts would be placed in the position of second-guessing business judgments as to what arrangements would or would not provide 'adequate' protection for legitimate commercial interests." See *Newberry* v. *Washington Post Co.*, 438 F. Supp. 470, 474-476 (D.D.C. 1977); cf. *Illinois Elections Board* v. *Socialist Workers Party*, 440 U.S. 173, 188 (1979) (Blackmun, J., concurring).

number of factors that are most significant to predicting the likely competitive effects of practices that may be viewed as tie-ins. The court of appeals, unfortunately, did not do this.

In sum, the decision below is far afield from the principles that led this Court to describe pernicious arrangements under the Sherman Act in *International Salt*, *Times-Picayune*, and *Fortner II*. We believe, therefore, that this case presents an appropriate opportunity for this Court to confirm the validity of the many judicial decisions that—unlike the decision below—have recognized that economic reality can offer valuable insight in the analysis of alleged tie-ins.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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No. 82-1031

In the Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 and EAST JEFFERSON HOSPITAL BOARD, PETITIONERS

v.

EDWIN G. HYDE, RESPONDENT

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE PETITIONERS

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QUESTION PRESENTED

Whether an arrangement by which a hospital secures the full-time, exclusive services of anesthesiologists to attend its patients is unlawful per se under the Sherman Act because it "ties" the patient's use of the hospital's operating room to the use of the hospital's anesthesiologists.

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EDWIN G. HYDE, RESPONDENT

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE PETITIONERS

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-19a) is reported at 686 F.2d 286. The opinion of the district court (Pet. App. 20a-47a) is reported at 513 F. Supp. 532.

JURISDICTION

The judgment of the court of appeals (Pet. App. 48a) was entered on September 20, 1982. The petition for a writ of certiorari was filed on December 17, 1982, and granted on March 7, 1983. The jurisdiction of this Court rests on 28 U.S.C. § 1254(1).

STATUTE INVOLVED

Section 1 of the Sherman Act, 15 U.S.C. § 1 (1976), provides in relevant part: "Every contract, combination

in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal."

STATEMENT

1. East Jefferson General Hospital is a large public hospital in the New Orleans metropolitan area.[1] See the maps at A. 35-37. At its opening in 1971 the Hospital concluded that anesthesia services would be best provided if the Hospital had the full-time services of one or more anesthesiologists. It accordingly invited anesthesiologists to make proposals for a contract to provide these services. 5-16 Tr. 128-131, 172-73.

After some negotiations, which included discussions with respondent, the Hospital entered into a contract with Roux & Associates ("Roux"), a professional medical corporation (Pl. Ex. 8; 5-15 p.m. Tr. 41; 5-16 Tr. 90). The contract was "exclusive": Roux promised that its anesthesiologists would not work elsewhere, and the Hospital agreed not to engage other anesthesiologists during its term. The term of the contract was one year,

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1. The Hospital is governed by petitioner Board of Directors, twelve people selected by petitioner Jefferson Parish Hospital District No. 2. The District is a political subdivision of the State of Louisiana. The Hospital was constructed with public funds in 1969. Day to day administrative decisions for the Hospital are made by an executive director selected by the governing body of the District. For convenience we refer to the two petitioners, the Hospital, and its executive director as "the Hospital."

The Hospital generally operates as a business, and petitioners have not argued that their decisions are protected by the state action doctrine of *Parker v. Brown*, 317 U.S. 341 (1943). See *Community Communications Co. v. City of Boulder*, 455 U.S. 40 (1982).

renewable for additional yearly periods unless either the Hospital or Roux should give 90 days' notice (A. 22 ¶ 17).

The Hospital was well satisfied with the services of the Roux anesthesiologists, and it allowed the contract to be renewed automatically until 1975, when it again reviewed the arrangement. It considered other options and proposals and once more selected Roux to provide services. 5-16 Tr. 133-35, 159-63, 200-01.

The contract signed in 1976 ran for five years (A. 23-28). Although it was not labeled "exclusive," it provided that Roux would supply all anesthesiology services required for the care of the Hospital's patients (A. 25; Pet. App. 2a n.1, 23a). Like the 1971 contract, this one also called for Roux to supervise the anesthesia department and the nurse anesthetists who performed many of the routine procedures (A. 23). It gave Roux the ability to hire and fire the nurse anesthetists who would be employed by the Hospital (A. 24). It gave the Hospital complete discretion to establish the charges to patients for anesthesia, requiring only consultation with Roux (A. 25-26). The fees of Roux were set at 46% of the total billings of the anesthesiology department; the remainder of the billings pay the nurses' salaries and compensate the Hospital for space, equipment, and supplies (A. 27). Roux thus was compensated whether its anesthesiologists performed the services or supervised their performance by nurse anesthetists.

Respondent applied in 1977 for a position on the Hospital's medical staff (A. 29-34). The Credentials Committee of the staff approved his credentials, but the Board of Directors declined to admit respondent to the

staff. It based this decision on the ground that the contract with Roux called for its anesthesiologists to supply all of the needed services (Pet. App. 25a-26a). Respondent then filed this suit under the Sherman Act, contending that the contract with Roux was unlawful because it "tied" patients' use of the Hospital's operating rooms to their use of Roux's services.[2] Respondent sought an injunction admitting him to practice in the Hospital, but he did not seek damages (A. 3-11).

2. The district court entered judgment for petitioners after a bench trial (Pet. App. 20a-47a). It assumed without discussion that the contract establishes a tie-in (*id.* at 33a) and applied the Rule of Reason to the contract because, it concluded, the Hospital has no significant market power.[3] It then held the contract lawful because it produces significant competitive benefits and no countervailing anticompetitive effects.

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2. Respondent also argued that the denial of his application for staff privileges violated the Fourteenth Amendment's due process clause (both substantively and procedurally) and two Louisiana statutes (A. 6-7, 9-10). The district court rejected all of these contentions (Pet. App. 42a-47a). The court of appeals did not reach them in light of its antitrust holding (*id.* at 5a n.3), and they are therefore not before this Court unless respondent should invoke them in support of his judgment. See *Rice v. Norman Williams Co.*, 102 S. Ct. 3294, 3301-02 (1982).

3. The district court also concluded that the Rule of Reason should be applied because of the special circumstances of the medical profession (Pet. App. 39a-41a). The court of appeals rejected this conclusion (*id.* at 14a-18a) in light of *Arizona v. Maricopa County Medical Society*, 102 S. Ct. 2466 (1982), and we have not presented this aspect of the Fifth Circuit's decision for review by this Court. We assume throughout this brief that the same antitrust principles apply to professional services as to other trades or businesses; respondent's assertion that we seek some special dispensation for hospital care (Br. in Opp. 9-14) is unfounded.

With respect to market power, the district court made a factual finding that the Hospital does not have "any advantages over any other hospitals in the area" (Pet. App. 34a) and is in no "position to charge patients higher prices or to impose burdensome terms which could not be extracted in a completely competitive market" (*ibid.*). It based this latter conclusion on findings that the Hospital competes for patients in the New Orleans metropolitan area (*id.* at 33a). The court observed that patients choose hospitals throughout the area and that only 30% of those who live in East Jefferson Parish obtain hospital care at the Hospital (*id.* at 33a, 38a-39a; see also A. 35 et seq. for the maps and patient origin data on which this finding is based). The court acknowledged that 70% of the Hospital's patients come from its neighborhood (*id.* at 39a) but reasoned that this does not show market power.

With respect to the benefits of the contract, the district court concluded that the arrangement ensured 24-hour service, "aids in the control and standardization of procedures and the efficient and less costly operation of the department[,] lends flexibility to the scheduling of operations[,] . . . permits the physicians, nurses and other technicians in the department to develop a work routine and a proficiency with the equipment they use in patient treatment; and it increases the Board's ability to monitor the medical standards exercised because there are fewer individuals involved" (Pet. App. 32a-33a; see also 5-15 a.m. Tr. 59-66, 74-75, 93; 5-16 Tr. 12-15, 172-73, 191-94 for supporting testimony). Moreover, the court explained, the contract did not suppress competition but rather created more competition: "A closed department may enhance competition among the hospitals in the market by increasing the quality of medical

care available. It may also serve to benefit competition among anesthesiology groups if the terms of the exclusive contract are not for unreasonable periods of time. Such a system would serve to encourage anesthesiologists to improve the quality of their services in order to obtain these contracts with hospitals" (*id.* at 34a). It therefore entered judgment for petitioners.

3. While the case was on respondent's appeal, petitioners moved to dismiss the appeal as moot because the 1976 contract had expired, the anesthesiology department was now "open," and respondent was free to apply for privileges. Respondent opposed the motion, which the court of appeals denied (A. 77-79).

We agree with the court that the case is not moot. The Roux anesthesiologists continue to have a position that is exclusive in fact, even though not made so by contract. Although voluntary discontinuation of the challenged acts would not moot the case, see *City of Los Angeles v. Lyons*, No. 81-1064 (Apr. 20, 1983), this case does not even involve voluntary discontinuation. The Hospital continues to have "closed" departments in radiology, pathology, cardiology, respiratory therapy, and emergency room services. The Hospital intends to review the status of anesthesiology as soon as the termination of this litigation permits. We therefore proceed as if the challenged 1976 contract were still in effect.

4. The court of appeals reversed on the merits. It first held that there is exclusivity in fact (Pet. App. 2a n.1). Then it concluded that the contract is a "tie-in" because patients in the "hospital's operating room (the tying product) are also compelled to purchase the hospital's chosen anesthesia service (the tied product). It is

also clear that we are dealing with two distinct services which a buyer should be able to obtain separately" (*id.* at 5a-6a).

It next held that the Hospital possesses market power as a matter of law because of "market imperfections in the health care industry" (Pet. App. 9a). Although the Fifth Circuit did not find any of the district court's conclusions clearly erroneous, it pointed to the fact that the Hospital is a nonprofit institution, to the prevalence of third-party payments that reduce the incentives of patients to shop for low prices, and to the patients' lack of complete information about the services they are buying; it also asserted that "patients tend to choose hospitals by location rather than price or quality" (*ibid.*). As a result, the court of appeals held, the geographic market is smaller than metropolitan New Orleans, the Hospital's market share is larger than the district court thought, and the Hospital thus has "sufficient market power in the tying product to coerce purchase of the tied product" (*id.* at 10a).

The court of appeals did not hold that the contract elevated prices of either anesthesia services or the package of operating rooms and anesthesia (Pet. App. 11a-12a). The court concluded, however, that constant or declining prices coupled with the lower costs of service made possible by the contract just led to profits for the Hospital, which demonstrated the vice of the contract (*ibid.*).

Finally, the court of appeals turned to the consequences of the contract. It held that the benefits found by the district court could not be used to sustain the contract because the Hospital had not established that a closed anesthesia department is the least restrictive

alternative for the creation of these benefits (Pet. App. 13a). Moreover, the court expressed doubts about the existence of these benefits. One finding, concerning the contract's utility in guaranteeing 24-hour service, was held clearly erroneous (*id.* at 3a-4a & n.2, 11a n.7); others, such as the findings concerning competition among anesthesiologists for the contract, were put to one side (*id.* at 12a n.9); still others, such as the findings concerning the supervision by Roux of the nurse anesthetists and the Hospital's supervision of Roux, were simply not mentioned.[4]

5. On April 28, 1983, the district court, acting pursuant to the court of appeals' mandate (which has not been stayed), ordered respondent admitted to the Hospital's staff pending proceedings in this Court.

SUMMARY OF ARGUMENT

A. The packaging and joint sale of multiple products is usually beneficial. Cars come with motors installed, razors with blades, hospitals with nurses, blood, and oxygen. This is advantageous for the same reason it is usually beneficial for business corporations to make more than one product apiece: there are savings from joint production and distribution. Antitrust law

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4. The court of appeals stated, for example, that the contract "reduces the incentive for improving or initiating techniques or procedures. Quality is lowered" (Pet. App. 12a). The court did not mention, let alone hold clearly erroneous, the district court's contrary finding of fact. (It did hold erroneous, *id.* at 11a n.7, any finding that "strictly quality considerations" account for the arrangement, but this appears to represent only a conclusion that some considerations *in addition to* quality motivated the Hospital's decision.)

recognizes and preserves these advantages. *United States Steel Corp. v. Fortner Enterprises, Inc.*, 429 U.S. 610 (1977) (*Fortner II*).

B. Joint sales of products are unlawful only when some feature distinguishes a given sale from its beneficial cousins. That feature usually is market power. But not just any market power with respect to customers will condemn a joint sale. It is only power that enables a firm to get a dispositive advantage over its rivals, and so create a further monopoly. *Fortner II* thus held that market power in a tie-in case means some feature of a product or arrangement that rivals cannot copy. When they can copy the package, the design of the package *is* competition on the merits.

C.1. The Hospital has many competitors. All can copy its methods of packaging medical services, and most do. The contract thus cannot create a monopoly of the package or a monopoly price for the package or its components.

C.2. Even if the Hospital has "market power" in a conventional sense, the exclusive anesthesiology agreement does not either exercise or augment the Hospital's power. The Hospital is in privity with every patient. It knows which ones have which operations. Thus if it is able to extract a monopoly price for its services, it can get that price by levying a high fee for an operation or a surcharge for anesthesia. Nothing depends on the Hospital's ability to contract for or furnish anesthesia services in any particular fashion. The arrangement thus cannot be an exercise of leverage from one monopoly profit to another.

D. Antitrust law encourages any firm, even one with market power, to save costs and increase the quality of its products. The arrangement challenged here does just that, as the district court found. It ensures the full attention of the anesthesiologists to the Hospital's patients, permits them to supervise and use the services of nurse anesthetists effectively, ensures that the Hospital can supervise the anesthesiology work, and so on.

The court of appeals' belief that the Hospital was spurred by profits to adopt the arrangement, and that it substitutes nurse anesthetists for anesthesiologists in some procedures, offers only praise. Profit is the drive of any competitive system. And it is desirable to furnish a service by using specialized non-physician medical staff if that reduces the costs of medical care without reducing quality.

E.1. At all events, the Hospital lacks the market power that would be the foundation for antitrust scrutiny. If the right perspective is power over charges to patients, the Hospital has none because there are tens of hospitals in the New Orleans area, and the Hospital must compete for the patients' custom. That some patients prefer nonprofit hospitals, or hospitals close to home, is irrelevant if enough other patients shop around that the Hospital must be competitive, as the district court found it to be.

E.2. The relation between Hospital and patients is not, however, the right focus. Any system of staffing restricts patients' choice of anesthesiologist to those admitted to practice in the Hospital. The locus of competition is obtaining a position on the staff. In the market in which anesthesiologists sell their services, there is competition in abundance. Anesthesiologists regularly

move from city to city, seeking positions. Hospitals solicit bids from out of town (and from out of the country too).

E.3. Although the contract does not permit respondent to compete for the right to serve each patient, there is nonetheless vigorous competition among anesthesiologists for the position. The fact that one bidder is unsuccessful in securing a position does not signal the elimination of competition. Competition for the contract is common in business, and here it was particularly effective.

F. The joint sale of operating rooms and anesthesia is not even a "tie-in", as antitrust defines that term. Products are deemed "tied" only when there is no good justification for their joint provision. Here there is such justification: no one wants operations without anesthesia, and patients do not purchase anesthesia as a distinctive product. They buy "surgery" and rely on the surgeon and the hospital to assemble the necessary complementary services. It is pointless for a court to compel competitors to tear asunder what patients want and need to purchase as a unit.

G. Ultimately this is an employment case. The exclusive arrangement with Roux is functionally identical to the Hospital's decision to employ anesthesiologists on its staff. It differs only in being easier to terminate an exclusive contract than to fire staff members, and thus the exclusive contract is better at preserving competition. If a nurse brought suit, claiming that the Hospital could not hire nurses for its staff but must accept freelance nurses roaming the halls looking for work, the Hospital would be given judgment on the pleadings. This is the same case.

ARGUMENT

BECAUSE IT CREATES NO HARM TO THE USERS OF MEDICAL SERVICES, THE EXCLUSIVE ANESTHESIOLOGY CONTRACT IS LAWFUL

A. *Packaging Two Products Together is Common and Beneficial*

We start from what must be common ground among the parties: there is ordinarily no antitrust objection to any firm's putting two or more things together and selling them as a unit. Such package sales are common and beneficial. Cars come with motors and tires, left and right shoes come in a box, a new razor may come with ten blades. Joint sales are as common in professional services as in manufactured goods. To get the top partner of a major law firm, the client must take the firm's associates. The podiatrist in a group practice of medicine (such as the Group Health Association) comes packaged with the group's dermatologist. Any hospital furnishes nurses, blood, oxygen, and hundreds of other complementary inputs that together make up the package of medical care it supplies to patients.

These things are put together and sold as a unit because there are substantial savings in joint sales. Cars *could* be furnished without engines or tires — airplanes often are sold that way — but it would impose needless costs on consumers if firms separately furnished products that consumers ordinarily combine anyway. It is better and cheaper to combine them at the plant in the first place. Similarly, the whole idea of law firms and the joint practice of medicine is that the cooperation of many people in the creation of a single, packaged product produces cost savings and other benefits.

People compete to create the methods of packaging and delivery that consumers want to purchase. There are both large law firms and solo practitioners. Consumers have a choice, and the method that best serves their needs will prosper. Similarly, some hospitals furnish anesthesia through contractual arrangements, others have open staffs, still others provide such services through full-time employees (who may be nurse anesthetists rather than anesthesiologists). Again consumers have a choice — giving them the choice *is* competition — and they can select which organizational method best serves their interests. In a competitive market one form may dominate (almost no one sells left shoes without right shoes, or cars without engines) or both forms may exist (solo and firm practice of law), but in either event the structure of the market is determined by what people want to buy.

Nothing in antitrust law prohibits producers from competing in the methods they use to create or package what they have to sell. *United States Steel Corp. v. Fortner Enterprises, Inc.*, 429 U.S. 610 (1977) (*Fortner II*), this Court's most recent tie-in case, makes that clear. U.S. Steel sold Fortner a package of prefabricated houses and credit, a package much more unusual than the one involved in this case. But the Court held the package sale lawful, for it appeared that many customers wanted to buy both houses and credit. Similarly, in *Times-Picayune Pub. Co. v. United States*, 345 U.S. 594 (1953), the Court sustained a package sale of morning and afternoon advertising. Even in *Northern Pacific Ry. v. United States*, 356 U.S. 1, 7 (1958), the high water mark of tying doctrine, the Court observed that "if one of a dozen food stores in a community were to refuse to sell flour unless the buyer also took sugar it

would hardly tend to restrain competition if its competitors were ready and able to sell flour by itself." The joint sale of products may have the same benefits as their joint production. Joint sales are, as a rule, no more objectionable than the formation of the firms that produce them. See also *Broadcast Music, Inc. v. Columbia Broadcasting System, Inc.*, 441 U.S. 1, 8 n.13, 9-10 (1979) (sustaining against per se antitrust challenge the joint sale of performing rights in music); *Arizona v. Maricopa County Medical Society*, 102 S. Ct. 2466, 2480 (1982) (group practice of medicine, which entails joint provision of services, is "perfectly proper").

B. *A Joint Sale May be Unlawful only if it has Anticompetitive Elements Distinguishing it from Ordinary Joint Sales*

If most package sales of products are beneficial to consumers and hence lawful, then there can be an antitrust objection to the Hospital's joint provision of operating rooms and anesthesia only if something distinguishes this from the other sales. That "something" must be a powerful distinction indeed in order to call the joint provision unlawful per se, as the court of appeals has done.

Practices may be condemned per se only when they have a "pernicious effect on competition and lack . . . any redeeming virtue" (*Northern Pacific, supra*, 356 U.S. at 5). "Per se rules of illegality are appropriate only when they relate to conduct that is manifestly anticompetitive." *Continental T.V., Inc. v. GTE Sylvania Inc.*, 433 U.S. 32, 50 (1977). See also *Broadcast Music, supra*, 441 U.S. at 7-8, 19-20; *National Society of Professional Engineers v. United States*, 435 U.S. 679, 692 (1978). Per se rules are based on the conclusion, drawn after

judicial experience with a particular class of industrial practices, that the likelihood of there being a beneficial example of that class is so remote, and the social gains from these scattered examples so small, that it is better to condemn the whole class than to spend time and money in litigation looking for the few beneficial examples. See *Continental T.V., supra*, 433 U.S. at 50 n.16.

Yet the discussion above, fortified by *Fortner II*, demonstrates that the joint provision of different products is not ordinarily pernicious. It is common and ordinarily beneficial. The producer's decision about how to package and sell things *is competition*, and a rule condemning package sales would reduce competition.

Fortner II holds that package sales are not unlawful at all, let alone unlawful per se, unless the seller has market power in the market for the tying good. Only then, the Court reasoned, could a joint sale be deleterious, presumably because the firm's market power might restrain competition for the package as a whole. (This is referred to in earlier cases as "leverage," the transfer of market power from one product to another.) The Court defined market power as the ability "to raise prices or to require purchasers to accept burdensome terms that could not be exacted in a completely competitive market" (*Fortner II*, supra, 429 U.S. at 620; footnote omitted). The Court also explained how to show this: "In short, the question is whether the seller has some advantage not shared by his competitors in the market for the tying product." *Ibid.*

The "advantage not shared by his competitors" is an essential link in the chain of reasoning by which a customary, procompetitive packaging of products can be turned into something unlawful per se. Only if a firm

has "some advantage not shared by [its] competitors" will competition fail to develop among different packages and packagers of products. Only if such competition fails to develop could a joint sale — even a joint sale by a firm with a large market share — increase whatever harm to consumers the market share alone would create.

If a firm's rivals can copy the package or mechanism it has created, then competition is not diminished by the packaging. In *Fortner II* itself, U.S. Steel's rivals were free to copy its package sale. That they chose not to suggested not an antitrust problem but just that U.S. Steel was "willing to accept a lesser profit" (429 U.S. at 621), or "to provide cheap financing in order to sell expensive houses" (*id.* at 622; footnote omitted). When other firms are able to "go ye and do likewise"[5] there is simply no risk of injury to consumers, and therefore no reason for illegality, whether under a Rule of Reason or a per se approach.[6] Leverage won't work.

C. *Other Hospitals Could and Did Use the same Packaging Methods as Petitioners, Making Leverage Impossible Even if it were in the Hospital's Interest to Attempt It*

Under the market power-leverage approach of *Fortner II* and earlier tying cases, there is no cause for antitrust concern about petitioners' conduct even if one

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5. Jones, *The Two Faces of* Fortner*: Comment on a Recent Antitrust Opinion*, 78 Colum. L. Rev. 39, 42 (1978).

6. For cases holding that the ability of rivals to mimic the defendant's practices negates any claim of illegal tying, see *Spartan Grain & Mill Co. v. Ayers*, 581 F.2d 419 (5th Cir. 1978), cert. denied, 444 U.S. 831 (1979); *General Business Systems v. North American Phillips Corp.*, 699 F.2d 965 (9th Cir. 1983).

assumes (which we dispute below) that the Hospital has some limited power to affect the price it charges to patients. There are two reasons for this. First, other hospitals could and did use the same method of delivering services. Second, because operations and anesthesia are delivered in fixed proportions at the Hospital, the packaging of operating rooms and anesthesia adds nothing to the Hospital's ability to collect from patients. Consequently, nothing the Hospital did could harm consumers' interests. If the Hospital lawfully may exist (and, we assume for now, exercise market power) there is no antitrust reason why it may not use any selling practice it likes, so long as the practice does not add to its power by excluding equally or more efficient rivals.[7] See *Berkey Photo, Inc. v. Eastman Kodak Co.*, 603 F.2d 263, 273-76, 286-88, 291-92 (2d Cir. 1979), cert. denied, 444 U.S. 1093 (1980) (even a monopolist may choose packaging methods that increase its market share, so long as it does not exclude competition or use leverage that wrongfully increases its monopoly profit; it is otherwise entitled to a "lawful monopoly profit") (collecting earlier cases).

1. Other Hospitals Commonly Furnish Operations and Anesthesia Together

Respondent is not the Hospital's competitor. The Hospital competes, rather, against other hospitals that put together medical care. And these other hospitals

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7. A firm with market power has no obligation to avoid harming less efficient rivals. Antitrust law exists to protect the welfare of consumers, not competitors, and it does not safeguard the interests of rivals for the rivals' sake. E.g., *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 487-88 (1977); *Continental T.V., Inc. v. GTE Sylvania Inc.*, *supra*, 433 U.S. at 53 n.21.

commonly use the practice challenged here. The district court found that it is a "common practice in the health care industry for hospitals to enter into exclusive contracts with physicians" (Pet. App. 32a). See also *Dos Santos v. Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346, 1351 (7th Cir. 1982) (similar arrangements are "widespread" and have "been adopted by most hospitals in the Chicago area").

Hospitals routinely put together services, including space, equipment, drugs, blood, nurses, food, and some medical specialties such as anesthesiology, radiology, and pathology, that are delivered to patients as a package of medical care. Data on just the three most common hospital-based specialties (anesthesiology, radiology, and pathology), summarized in our petition for certiorari (Pet. 10-11), demonstrate that approximately half of all hospitals in the United States have exclusive contracts for the provision of one or more of these services, and half of all medical professionals rendering these services do so under exclusive contracts. The figures are probably higher than 99 percent for nursing, food, oxygen, and the other components of medical services that any hospital assembles for the benefit of its patients.

The prevalence of exclusive contracts also is illustrated by the number of antitrust attacks waged against them. There have been many in the last few years, although until now every court that has considered an antitrust attack on such assembly of medical services had upheld the hospital.[8] The Federal Trade Commission has issued an advisory opinion about hospitals'

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8. E.g., *Smith v. Northern Michigan Hospitals, Inc.*, 1983-1 Trade Cas. ¶65,289 (6th Cir. Mar. 25, 1983) (rejecting a challenge to

exclusive contracts for medical services. The FTC unanimously took the position that such contracts are not unlawful, in large part because exclusive contracts are a way for one hospital "to compete with other hospitals by obtaining efficiencies and a desired level of quality and service."[9]

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an exclusive staffing arrangement for emergency rooms); *Dos Santos, supra* (adopting the reasoning of the *district* court in this case and rejecting an argument that exclusive medical contracts amount to a boycott or other per se violation); *Harron v. United Hospital Center, Inc.*, 522 F.2d 1133 (4th Cir. 1975), cert. denied, 424 U.S. 916 (1976) (an antitrust challenge to an exclusive medical contract is so "frivolous" that the suit must be dismissed for want of federal jurisdiction); *Capili v. Shott*, 620 F.2d 438 (4th Cir. 1980) (exclusive arrangement is reasonable and challenge also fails to show effect on interstate commerce); *Robinson v. Magovern*, 521 F. Supp. 842, 919 (W.D. Pa. 1981), aff'd mem., 688 F.2d 824 (3d Cir. 1982), cert. denied, Nov. 1, 1982, No. 82-415 (by using a closed staff the hospital has built a "high quality staff" and "improved its ability to compete"; rejecting a large number of different antitrust claims).

Every state court that has encountered similar claims under state antitrust law also has sustained the hospitals' practices. *Rumple v. Bloomington Hospital*, 422 N.E.2d 1309 (Ind. App. 1981); *Centeno v. Roseville Community Hospital*, 167 Cal. Rptr. 183 (Cal. App. 1979); *Dattilo v. Tucson General Hospital*, 23 Ariz. App. 392, 533 P.2d 700 (1975); *Letsch v. Northern San Diego County Hospital District*, 55 Cal. Rptr. 118 (Cal. App. 1966); *Blank v. Palo Alto-Stanford Hospital Center*, 234 Cal. App. 2d 377, 44 Cal. Rptr. 572 (1965).

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9. For the convenience of the Court, we reproduce the advisory opinion as Appendix A to this brief. The quoted portion appears at A-7.

2. The Exclusive Service Contract Cannot be Used by the Hospital to Augment any Market Power it May Possess

Because other hospitals can and do use the same method of staffing as petitioners, there is nothing unique about petitioners' product and methods, no "advantage not shared by [the Hospital's] competitors," (*Fortner II*, supra, 429 U.S. at 620), and no reason for antitrust concern. The district court found, as a matter of fact, that the Hospital has no special advantage (Pet. App. 33a-34a), and the court of appeals did not conclude that this finding is clearly erroneous. In light of the prevalence of exclusive contracts, it could not have disturbed the district court's finding.

The court of appeals instead bypassed the whole controversy by holding that the Hospital has market power vis-a-vis patients. We dispute this at pages 30-34 below. For now, however, there is a more important point: *Even if* the Hospital has its patients over a barrel, the exclusive anesthesiology arrangement does not make the patients any worse off. Instead it almost surely makes them better off. So there is no ground of antitrust condemnation.

Fortner II establishes that if a package sale simply entails a low price on one item and a high price on another, there is no antitrust problem. "Cheap financing in order to sell expensive houses" (429 U.S. at 622) is perfectly lawful. This is because the leverage objection to tie-ins is that the price of the package rises as it partakes of the tying good's monopoly power. If this

does not or cannot happen — if, as in *Fortner II*, the package sells for an unchanged price) — there is no violation.[10] No one is harmed.

Respondent has not alleged, and the court of appeals did not find, that the anesthesiology arrangement caused an increase in the price of the operating room — anesthesia "package." To the contrary, the court observed that the price of anesthesia had not risen (Pet. App. 11a-12a), and it did not suggest that there was a corresponding rise in the price of operating room time. Because antitrust law is a "consumers' welfare prescription"[11] and is directed only against practices that reduce consumers' welfare, that should have been the end of this case.

There is, moreover, a reason why an exclusive contract *cannot* harm users of medical services. In most tie-in cases, such as IBM's lease of tabulating machines on condition that lessees buy cards as well, and International Salt's sale or lease of salt-injecting machines tied to salt, the purpose or function of the tie is to compel

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10. E.g., *Kypta v. McDonald's Corp.*, 671 F.2d 1282 (11th Cir. 1982), cert. denied, Oct. 4, 1982, No. 82-6, holding in light of *Fortner II* that a tying complaint must be dismissed on the pleadings unless the plaintiff offers to prove that the tie-in increased the price of the package over what it would be in the absence of the joint sale; *General Business Systems v. North American Phillips Corp., supra.*

11. E.g., *Reiter v. Sonotone Corp.*, 442 U.S. 330, 343 (1979), quoting from R. Bork, *The Antitrust Paradox* 66 (1978). See also *Broadcast Music, supra; Continental T.V., supra; Brunswick, supra; Valley Liquors, Inc. v. Renfield Importers, Ltd.*, 678 F.2d 742, 745 (7th Cir. 1982); *Products Liability Ins. Agency, Inc. v. Crum & Forster Insurance Cos.*, 682 F.2d 660, 663 (7th Cir. 1982).

the user to buy from the vendor a good it would ordinarily buy from someone else. *IBM v. United States*, 298 U.S. 131 (1936); *International Salt Corp. v. United States*, 332 U.S. 392 (1947). Unless it compelled or induced the buyer to take *its* cards or salt, the defendant had no way to extract any profit on those sales.

Here, however, the ratio of operating rooms to anesthesia is fixed — each patient (except the foolhardy) will use anesthesia on each operation. The Hospital is in privity of contract with the patients, and it knows how much anesthesia each patient requires. If "imperfections" in the market for medical services enable the Hospital to raise the price of medical care, it can do so no matter how patients secure anesthesia. The Hospital will just increase the price for operating room time until it has extracted the full profit available. If it wants, it can levy an anesthesia surcharge. In either event, nothing turns on whether the Hospital has an exclusive contract for anesthesia. The patient's bill is unaffected. See also 5 P. Areeda & D. Turner, *Antitrust Law* ¶1134 (1980).

Indeed if, as respondent says, the exclusive contract reduced competition in the market for anesthesia, the Hospital harmed only itself. The cost of anesthesia is ultimately borne by the patient, who sees it as part of the cost of medical care. If the Hospital has market power, it wants to hold as low as possible the costs of all medical services other than its own. If it allows the price of anesthesia to rise, or the quality to fall, it is shooting itself in the foot. It loses the opportunity to keep for itself all that the traffic will bear. No firm, no matter

how much market power it has, wants to increase the cost of an input into its own production. See *Continental T.V., Inc. v. GTE Sylvania Inc., supra.*

So market power is an implausible explanation for the exclusive contract, and damage to consumers of medical care is an impossible consequence of it. On the assumption that the Hospital has market power, the arrangement just makes the patients better off by reducing the costs (or increasing the quality) of anesthesia. If a monopolist reduces its costs, at least some of the reduction will be passed on to the consumer.[12] Consumers therefore want any firm, no matter how much market power it possesses, to assemble its products in the least-cost fashion. For reasons we discuss next, an exclusive contract may well enable the Hospital to reduce its costs and increase the quality of its services.

D. *Exclusive Contracts for Medical Services May Enable Hospitals to Perform Those Services More Efficiently*

After hearing the evidence, the district court found that the contracts at issue enabled the Hospital to deliver better service at lower cost (Pet. App. 32a-34a). The FTC, which has a special expertise in medical service questions, agrees. Its recent advisory opinion on this subject recites that exclusive contracts "can facilitate efficient delivery of services" by ensuring, among other benefits, "full-time availability of services, lower costs of standardization of procedures and centralized

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12. How much depends, as the Court observed in a related pass-on context, on the elasticity of demand. *Illinois Brick Co. v. Illinois*, 431 U.S. 720, 741-42 (1977). See also 2 Areeda & Turner, *supra* at ¶408a; Posner, *Oligopoly and the Antitrust Laws: A Suggested Approach*, 21 Stan. L. Rev. 1562, 1585-87 (1969).

administration . . ., [and they] permit better scheduling of the use of facilities, facilitate maintenance of equipment, improve supervision of support staff . . . and improve the quality of services by assuring that physicians perform enough procedures to maintain their proficiency" (App. A, *infra*, at A-5). This is substantially the same list of benefits the district court found in this case. See also 3 Areeda & Turner, *supra* at ¶733c.

The nature and source of most savings is apparent. The brief of the American Hospital Association, as amicus curiae, elaborates on them. One source of the benefits deserves special comment, however.

Several of the gains from exclusive medical service arrangements are attributable to the allocation of duties between anesthesiologists and nurse anesthetists that the arrangement made possible. Because Roux is responsible for all anesthesia in the Hospital and is paid no matter who provides a given service, it uses whichever of the services is best for the patient. Because anesthetists and anesthesiologists cooperate, Roux's four anesthesiologists can cover the fourteen operating rooms in the Hospital. Highly specialized medical professionals can take the place of the more expensive anesthesiologists. In an "open" department, by contrast, anesthesiologists will try to supply their own services even though a particular procedure could be performed more effectively, and at lower cost, by the nurse anesthetists who operate under the constant guidance of Roux in the Hospital's "closed" department. This is innovative cost-saving technology at work,

made possible by the agreement. An "open" department would destroy both the incentives and the supervision that make these savings possible.[13]

The court of appeals responded to the proof of benefits by holding clearly erroneous the district court's conclusion that the arrangement ensured 24-hour service (Pet. App. 3a-4a & n.2, 11a n.7). We doubt that this finding was clearly erroneous, but we let the matter pass because there are so many other benefits, unquestioned by the court of appeals. The court of appeals' bald assertion that "quality is lowered" (*id.* at 12a) is simply untenable in light of the undisturbed factual findings of the district court.

The court of appeals also held that reasons in addition to "strictly quality considerations" (*id.* at 11a n.7) account for the arrangement. By this it apparently meant that the Hospital acted with a view to reducing the cost of service and, hence, increasing its "profit" (an odd term for a non-profit institution). The court stated that there was "testimony that the profit motive caused the hospital to hire nurse anesthetists in place of needed

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13. Another benefit is the elimination of free riders. Someone must coordinate the anesthesia department, train technicians, provide 24 hour coverage, and generally keep services up to snuff. An open department makes these things hard to accomplish; each physician may try to "skim the cream" of procedures while leaving "routine" or "housekeeping" chores to others, leading to a deterioration of quality. See 5-16 Tr. 195. This Court recognized in *Continental T.V., Inc. v. GTE Sylvania Inc.*, *supra*, 433 U.S. at 49, that the elimination of such free riding is a benefit of some forms of exclusive contracting. See also *USM Corp. v. SPS Technologies, Inc.*, 694 F.2d 505, 514 (7th Cir. 1982) ("[A]ntitrust law increasingly is tolerant of contractual arrangements that reduce free rider problems and thereby increase competition.").

anesthesiologists, a practice which dilutes the professional coverage available" (*id.* at 12a). (Perhaps this is why the court thought that "quality is lowered".)

Two things are wrong with this. First, there is nothing improper about cost reductions motivated by profit. Cost reductions are a boon, to be encouraged by antitrust, and the lure of profit is the engine that propels firms to save costs and offer services consumers prefer. It is bizarre for a court in an antitrust case to condemn actions simply because undertaken in pursuit of profit.

Second, the court of appeals appeared to be of the view that the use of nurse anesthetists presents an antitrust problem because physicians are more skilled. There is no support for the view that physicians must render all medical services, any more than there would be support for a view that surgical nurses should be expelled from operating rooms because they are inferior substitutes for surgeons. To the contrary, prevailing medical practice today emphasizes the use of nurse anesthetists.[14] Every hospital puts together medical professionals with a variety of skills, some of them specialized to the ordinary case and some adapted to the

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14. The record shows that every hospital in New Orleans uses nurse anesthetists, that respondent's anesthesia group at Lakeside Hospital (where respondent is chairman of the department of anesthesia) has ten nurse anesthetists to support anesthesiologists, and that respondent's anesthesiology expert, Dr. Adriani, conceded that supervised nurse anesthetists play a proper role in rendering service. 5-16 Tr. 23, 32, 55, 63, 107. Some hospitals provide complete coverage using nurse anesthetists. 5-15 p.m. Tr. 78-79. It was estimated at trial that without nurse anesthetists only 10-20% of the current level of care could be provided in New Orleans, and that their elimination would result in tremendous increases in the cost of service. 5-15 a.m. Tr. 65-66; 5-15 p.m. Tr. 41, 80-81.

more complex matters. It is wise to conserve the most highly-trained specialists for the cases where they are needed, using other professionals when their skills match the job's requirements. That is what the Hospital has done by encouraging the use of nurse anesthetists. As the Solicitor General put it, "the antitrust laws were promulgated to promote, not frustrate, the entry of competitive alternatives. The antitrust laws should not be transformed into a tool that allows competitors to prevent competition by competent, state-licensed, non-physician health care providers" (US Br. in Support of Cert. 10 n.11).

Finally, the court denigrated the efficiencies by saying that the exclusive arrangement was not the least restrictive way to obtain them (Pet. App. 13a-14a). It recommended, for example, closer supervision by other personnel (*id.* at 15a).[15] The court erred in consigning all benefits to the least restrictive alternative dustbin. Nothing ever passes the least restrictive alternative test, because one can always *imagine* some less restrictive rule that, in a hypothetical world, produces benefits without corresponding costs. "A judge would be unimaginative indeed if he could not come up with something a little less 'drastic' or a little less 'restrictive' in almost any situation" (*Illinois Election Board v. Socialist Workers Party*, 440 U.S. 173, 188 (1979)

15. The court apparently thought, contrary to all of the evidence in the record, that the process of checking the credentials of physicians applying for membership on the staff would ensure high-quality service. The evidence discussed elsewhere in this brief shows, however, that the Hospital wants more than minimally-credentialled staff; it wants staff working in an environment, and under incentives, that assure high quality of work as well as high paper achievements.

(Blackmun, J., concurring)). The degree of economic integration is variable in any business. Some pen manufacturers make their own ink, while others buy ink from specialty firms. Some hospitals have "open" departments of anesthesiology, while most have "closed" departments.

A "least restrictive alternative" approach stifles beneficial innovation in the delivery of professional services. No other court takes such an approach to antitrust matters.[16] One cannot show that any given arrangement is perfect or costless. Nonetheless, the benefits of the arrangement — including most particularly the supervision of the nurse anesthetists — lie at the heart of the case. They illustrate why the Hospital used exclusive arrangements rather than an open department. A court cannot sweep them aside as irrelevant (except to a defense that can never be made out) without missing the whole point of tie-in doctrine. Courts call some practices tie-ins because of a belief that putting odd products together in a package hardly ever serves a purpose besides restricting competition. They call other practices (such as selling cars with motors already in them and ball point pens with refills in them) not tie-ins because the gains produced by such prepackaging are apparent. The savings to be had from a practice are pertinent both to the characterization of the practice as a tie-in and to the question whether the

16. See *Continental T.V., Inc. v. GTE Sylvania Inc.*, 694 F.2d 1132, 1138 n.11 (9th Cir. 1982) (rejecting least restrictive alternative approach, in reliance on *Continental T.V., supra*, 433 U.S. at 58 n.29).

practice, so characterized, must be held unlawful per se. Cf. *Continental T.V., Inc. v. GTE Sylvania Inc., supra*; *Broadcast Music, supra.*

The benefits in this case are the same as those of selling cars with motors. They are the benefits of economically-integrated production. They are the sort of gains from coordination that any firm achieves by hiring workers and putting them together in teams. Boeing hires its engineers, rather than subcontracting each specialized task or allowing engineers to roam the halls looking for work in an "open" engineering department. The benefits from coordination are why firms grow and prosper. They are why, as the Court said in *Arizona v. Maricopa County Medical Society, supra*, 102 S. Ct. at 2480, complete medical coverage by cooperating doctors in a clinic would be "perfectly proper."

E. *The Hospital Lacks Market Power*

If the Court accepts the argument to this point, the case is over. Whether or not the Hospital possesses market power, the packaging of anesthesia with operations cannot be an *exercise* of that market power. It cannot harm patients (the Hospital bills them no matter what) or other hospitals (which can copy the arrangement if they wish). Its only effect is to help patients if, as the district court found, it enables the Hospital to deliver better service at lower cost. No matter what the Court makes of these arguments, though, the Hospital does not possess market power, and *Fortner II* requires a decision in its favor.

1. The Hospital has no Power vis-a-vis Patients

The district court found that the Hospital cannot charge higher prices to its patients, because they can go elsewhere (Pet. App. 33a-34a). The record supports this finding.

There are at least 31 hospitals in the New Orleans metropolitan area (the Census SMSA). The Hospital's patients may choose among them, and there are at least 12 more hospitals on the fringes of the Census SMSA.[17] (The data summarized here, and their sources, are presented in more detail in Appendix B to this brief.) The Hospital is the fourth-largest of these 31 or 43 hospitals.

If the area of practical choice open to patients is the SMSA, then the Hospital's market share is uniformly less than 10%. By the standard of total patient admissions, the Hospital draws about 7.1%. It has 5.4% of the beds (440 of 8144 available). It logs about 6.2% of the patient days (reflecting a higher average bed occupancy, which attests to competive success and high quality rather than monopoly power). If, as the district court assumed, the area of choice is the smaller "East Bank" portion of Jefferson and Orleans Parishes (the city of New Orleans proper), these figures rise to 9.0% of admissions (8211 of 91084), 7.1% of beds (440 of 6231), and 7.7% of average daily occupancy (353 of 4559). If one narrows it still further by counting only patients who live in East Bank Jefferson and Orleans, and use a hospital in these areas, the admissions figure is 10.7%.

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17. There are 43 hospitals in the service area defined by the Health Systems Agency (5-16 Tr. 125; A. 36-38) and 345 in the state of Louisiana (5-15 p.m. Tr. 73).

By any standard, these are not large market shares, even when the geographic and patient-origin base is narrowed. On a SMSA basis, the share of all beds in the four largest hospitals is 34.0%, and the Herfindahl-Hirschman Index is 564. (The Antitrust Division's 1982 Merger Guidelines explain the computation and use of the Index, which must reach 1000 before a market is deemed even slightly concentrated.) Other methods of computing share yield higher numbers (App. B, *infra*), but none shows any significant risk of market power. In case after case, markets of substantially greater concentration have been found to lack any market power.[18]

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18. See Landes & Posner, *Market Power in Antitrust Cases*, 94 Harv. L. Rev. 937 (1981), for the theory of market power and a collection of the cases. See also, e.g., *Fortner II* (U.S. Steel lacks market power in housing and credit markets); *Northern Pacific* (a grocery store in a small town lacks market power if other stores are available); *United States v. E.I. DuPont de Nemours & Co.*, 351 U.S. 377 (1956) (sole maker of cellophane lacks market power because of competition from other flexible wrappings); *Spartan Grain, supra* (sole seller of a chicken-grain package lacks market power because other firms could copy the arrangement); *Dimmitt Agri Indus., Inc. v. CPC International Inc.*, 679 F.2d 516 (5th Cir. 1982), cert. denied, No. 82-1347, Apr. 18, 1983 (25% share insufficient as a matter of law); *Broadway Delivery Corp. v. United Parcel Service of America, Inc.*, 651 F.2d 122 (2d Cir. 1981) (firm with almost 50% of package deliveries lacks market power because it cannot exclude new entry); *Kingsport Motors, Inc. v. Chrysler Motors Corp.*, 644 F.2d 566, 571 (6th Cir. 1981) (firm with at least a 10% share of the concentrated mid-sized car market lacks market power); *Yentsch v. Texaco, Inc.*, 630 F.2d 46, 57-59 (2d Cir. 1980) (Texaco lacks market power in concentrated gasoline market because it did not dominate the market); *In re Data General Antitrust Litigation*, 529 F. Supp. 806 (N.D. Cal. 1981) (second-largest seller of minicomputers lacks power as a matter of law; contrary jury verdict overturned).

The court of appeals recognized that the district court had applied "a traditional method of economic power analysis" (Pet. App. 8a) and apparently thought that in most cases the sellers in such a market would have no power (*id.* at 9a). Nonetheless, it held, the Hospital has power as a result of a concatenation of "market imperfections" (*ibid.*). The public prefers nonprofit hospitals, the court thought; moreover, "the prevalence of third party payment of bills eliminates a patient's incentive to compare the relative cost" of hospitals (*ibid.*), and there is "a lack of complete information regarding the quality of medical care offered" (*ibid.*). Finally, patients prefer "to select the hospital closest to home" (*ibid.*; see also *id.* at 7a-8a). The court thought these things, taken together, so dulled patients' sensitivity to price that the Hospital could exploit them. The court is wrong. Neither singly nor in concert do its assertions justify setting aside the district court's findings.

No evidence in the record supports the view that the medical care industry is generically noncompetitive, and this cannot be the subject of judicial notice. This Court's decision in *Arizona v. Maricopa County Medical Society, supra*, is based on a belief that the provision of medical care is ordinarily competitive.

The court of appeals' "evidence" of imperfect competition concerned the lack of complete information, the prevalence of insurance, and other features present in most markets to some degree. Lack of perfect information is endemic in consumer goods markets. Competition nonetheless exists because some people search and tell others what they found, and some producers

advertise.[19] Those who search protect the others, because firms must set the competitive price to attract the searchers. Similarly, surgeons and other knowledgable people almost always choose the hospital and anesthesiologists for surgery, again protecting patients from overreaching.

As for insurance: this exists in the housing and auto markets too. The insurance in medical markets is incomplete. Many policies have coverage limits or require "copayments" (such as a 20% contribution toward all costs incurred) that make patients sensitive to cost. In 1981 at least 9% of all hospital revenues came directly from patients' pockets. *Socioeconomic Issues of Health 1981*, Table 42 (AMA 1981). Insurance companies and governmental agencies have established cost-containment systems that serve in part as replacements for patients' price-searching incentives that are diminished by insurance.[20] Even if insurance dulls patients' sensitivity to price, it does not reduce (and may even enhance) their desire to obtain the highest quality care. There will be keen competition among hospitals to serve the demand for quality medical care.

A court thus cannot take ignorance and insurance as establishing market power without proof. It probably

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19. See Schwartz & Wilde, *Intervening in Markets on the Basis of Imperfect Information*, 127 U. Pa. L. Rev. 630 (1979), for a comprehensive discussion.

20. For some examples, see *Arizona v. Maricopa County Medical Society*, *supra*, 102 S. Ct. at 2477-78 & nn. 26, 28; *Union Labor Life Insurance Co. v. Pireno*, 102 S. Ct. 3002 (1982); *National Gerimedical Hospital v. Blue Cross*, 452 U.S. 378 (1981).

cannot use them as indicia of market power at all without holding that all sellers in all markets have market power.

The fact that people who live near the Hospital prefer to use its services also does not establish market power — at least not unless every corner grocery has market power as a matter of law. A small grocery draws most of its customers from its neighborhood even if it is in the shadow of a large supermarket and even if 95% of the people in the neighborhood use the supermarket. The origin of its customers would prove nothing about market power. The same is true here. There is no proof that the Hospital could charge elevated prices because of this preference (or any preference for nonprofit institutions). The district court found that it could not (Pet. App. 34a, 38a-39a). The preference of neighbors probably reflects the Hospital's good service and competitive prices rather than monopoly power.

Finally, everything the court of appeals said about this Hospital would be true of every other hospital in New Orleans and the nation as a whole. The Hospital has no power relative to other hospitals, no advantage they lack, and thus no market power within the meaning of *Fortner II*.

2. The Appropriate Market Perspective is the One in which Anesthesiologists Compete to Sell their Services to and Through Hospitals

Ultimately the question whether the Hospital has market power vis-a-vis its patients is irrelevant. We have explained above that the Hospital's exclusive arrangement with Roux neither augments nor exercises such power. Moreover, so far as patients are concerned, either "open" or "closed" departments restrict the

choice of anesthesiologists to those admitted to practice in the hospital. The difference between open and closed departments therefore affects only the market in which hospitals secure, and physicians sell, anesthesiology. It is a physician, after all, and not a patient, who brought this case. The physicians' market — the one in which respondent sought employment, the one to which the Hospital turned to staff its department — is the one that matters. See *Dos Santos, supra*, 684 F.2d at 1354.[21] See also *RCM Supply Co. v. Hunter-Douglas, Inc.*, 686 F.2d 1074, 1076-77 (4th Cir. 1982).

This position follows not only from the nature of the competition affected by the contract but also from *Tampa Electric Co. v. Nashville Coal Co.*, 365 U.S. 320 (1961). In *Tampa* an electric utility signed a 20-year exclusive contract for coal. This Court sustained the contract under the antitrust laws because, it held, the contract affected only a minuscule portion of the relevant market. There were two possible markets in *Tampa*: the electric service market, in which Tampa Electric had a monopoly (corresponding to the market in which the Hospital serves patients), and the coal market, in which sellers of coal competed to sell to utilities. The Court selected the latter, because that was the one affected by the contract. The buyers of electricity

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21. "The patient... receives the services but does so without making any significant economic decision. It may thus be more appropriate for antitrust purposes to treat the *hospital* as the purchaser, in view of the hospital's responsibility for assuring the availability of anesthesia services for its patients.... If the hospital... is regarded as the purchaser, the relevant market could be defined as the area... in which the [hospital] (rather than the patient) can practicably turn for the alternative provision of anesthesia services."

did not care how the utility got its coal. See also *United States v. General Dynamics Corp.*, 415 U.S. 486 (1974) (analyzing competition in the market to sell contracts for coal delivery). The same principle applies here. If one wants to analyze whether the exclusive anesthesiology arrangement affects competition, one must look at where and how anesthesiologists compete.

3. There is a National, Competitive Market among Anesthesiologists for Placement in Hospitals

There is a national market in anesthesiology. Many anesthesiologists are born in one city, receive their medical training in a second, are residents in a third, and practice in several more over the course of their lives. The American Society of Anesthesiologists (ASA) maintains a national placement service, as do other medical specialties. The national medical journals carry placement ads. Respondent received his undergraduate education in San Diego, his graduate education in New Orleans, and practiced in Miami before returning to New Orleans (A. 29). He is licensed in California as well (A. 30). Respondent was the placement chairman of the Louisiana chapter of the ASA, and he testified that he received a "fair number" of inquiries from anesthesiologists in other states seeking to relocate to New Orleans (5-16 Tr. 92-93). Respondent's two associates came from Florida (5-16 Tr. 69). Dr. Roux did his internship and residency in Minnesota (5-15 p.m. Tr. 39).

Mobility is common because anesthesiologists are selected by hospitals and surgeons rather than patients. They rarely build up the sort of personal practice that ties general practitioners to a single location. As Dr. Adriani, respondent's expert, said: "Anesthesiologists...are like nomads. They can pick up and leave

and go to another community. They don't have an office and the clientele .... So it's very simple for an anesthesiologist to say, well, I'm going to move to Florida, or I'm going to move to California" (5-16 Tr. 49; see also A. 52-53, 64 for Dr. Adriani's history of migration). Census data place physicians as a whole among the most mobile professional groups. See U.S. Census, Mobility for States and the Nation 38-44 (PC(2)2B) (1970 data).

Surely respondent's "foreclosure" from obtaining one of the four positions at the Hospital does not affect competition in any discernable fashion. He competed for the position at the Hospital in 1971, and he lost out (5-16 Tr. 195). He was (and is) fully employed at another hospital (5-16 Tr. 66). He has the rest of the Nation in which to sell his services. The Hospital has the rest of the Nation and much of the world from which to secure anesthesiologists, too. Respondent's current inability to obtain the Hospital's work, case-by-case, is immaterial in this larger perspective.

Moreover, as *Tampa*, *General Dynamics*, and many other cases[22] hold, there is no inconsistency between long-term contracting and competition. Quite the contrary, as the district court observed, exclusive contracts "serve to benefit competition among anesthesiology groups if the terms of the contracts are not for unreasonable periods of time. Such a system would serve to encourage anesthesiologists to improve the quality of their services in order to obtain these contracts with hospitals" (Pet. App. 34a). Competition for the contract

22. E.g., *United States v. El Paso Natural Gas Co.*, 376 U.S. 651 (1964); *Dos Santos, supra*; *Fleer Corp. v. Topps Chewing Gum, Inc.*, 658 F.2d 139 (3d Cir. 1981); *Omega Satellite Products Co. v. City of Indianapolis*, 694 F.2d 119 (7th Cir. 1982).

is as vital as competition for "spot" sales. See 5-15 a.m. Tr. 86 (testimony of Hospital's administrator). It may be more vital still, because it requires rivals to focus their energies on improving their quality or reducing cost in order to impress hospitals that can make detailed inquiries, while "open" departments do not entail such concentrated scrutiny. See 5-16 Tr. 203.

Respondent understood this very well. He testified that he did not want to bid for an exclusive contract, because: "[T]hat gets to practice by the lowest bidder. And I think that's not our intent in the practice of medicine." 5-16 Tr. 76. Perhaps antitrust law does not *require* "practice by the lowest bidder." It is simply flabbergasting to be told, however, that antitrust is offended by competition with this result.

Competition for the contract is common in industry. Every year General Motors puts up for bids the contracts to supply tires. If Firestone wins in 1984, a court would not listen to Goodyear's complaint that it had been "foreclosed" from selling to GM in that year, or that competition had been diminished. There was competition aplenty. Similarly, there was competition to supply the engines for the Boeing 727, the largest-selling commercial airplane ever. Boeing picked Pratt & Whitney's JT-8D engine, which powers every 727. General Electric could not complain that this is an antitrust violation. The fact that Pratt & Whitney held the Boeing contract for so long does not show a lack of competition. It shows, and the success of the 727 attests, the power of competition for the contract in producing better products at lower prices. Thus the court of appeals' decision to ignore this form of competition because Roux has held the Hospital's position for 10 years (Pet.

App. 12a n.9) gets things backwards. That the arrangement has lasted so long — through year-to-year renewals and a second round of bids in 1976 — illustrates the success, not the failure, of this competition.

F. *Anesthesia and Operating Rooms are One Product*

We have assumed throughout this brief, as the court of appeals held, that "we are dealing with two distinct services" (Pat. App. 5a) to which tie-in principles apply. The court thought they are two products because they can be supplied separately. In a sense this is true: operating rooms are not at all "like" anesthesiology, and the two are not combined (as buttons are combined with cloth) to produce a single recognizable entity. There is nothing inevitable about their joint provision. At hospitals with "open" departments they are supplied by different parties, and dentists supply anesthesia without surgery.

Nonetheless, this does not mean that anesthesiology and operating rooms are different products for *antitrust* purposes. The definition of a product is inevitably arbitrary. Every component of an automobile's engine can be and is sold separately to auto repair shops, yet we have no difficulty recognizing an assembled engine as a single product. Anesthesiology and operating rooms are a single product in the same sense. They are a product because it is often more economical to supply them together than to supply them separately.[23]

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23. Respondent argues (Br. in Opp. 16) that we did not preserve in the Fifth Circuit the argument that there is only a single product. We agree with respondent that the argument was not made there as unmistakably as we make it here. But petitioners did argue, and the district court held, that the combination of anesthesia and operating rooms is beneficial and cost-reducing. The court

The challenged arrangement *creates* a unified medical service, which the Hospital furnishes to patients.[24] The fact that the Hospital could conduct its business so as to multiply the number of products is irrelevant. What makes a tie is the fact that two items, each *independently* useful, are put together and the customer coerced to take both even though he needs but one. What makes a single product is the fact that the package sold is conveniently used as a unit. Many cases hold that there is no tie if the products are frequently used together; surely there is none, they say, if the products are not sold in separate markets.[25]

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of appeals addressed these arguments. As we argue in the text, these are the criteria that define a single product. Thus the argument was presented in functional terms.

24. Respondent says (Br. in Opp. 16-17) that it is impermissible to treat the Hospital as furnishing medical care to its patients because only the surgeons, anesthesiologists, and other professionals are licensed to practice medicine. This is a wholly formal response. Only attorneys are licensed to practice law, yet it is quite appropriate to think of a law firm, a collective and perhaps corporate entity, as the seller of legal services. The Hospital furnishes medical care in the only senses that matter for antitrust: it is the locus of competition against other hospitals, and it is the place patients go when they seek care. (If this is important, though, Louisiana law makes the Hospital responsible for the quality of all care furnished there. E.g., *Dillon v. Hospital Affiliates*, 407 So.2d 493, 496 (La. App. 1981), holding a hospital responsible for ensuring that its patients receive "due care under the circumstances" from the medical staff.)

25. See, e.g., *Times-Picayune, supra*; *Hirsh v. Martindale-Hubbell, Inc.*, 674 F.2d 1343 (9th Cir. 1982), cert. denied, Nov. 1, 1982, No. 82-570; *Klamath-Lake Pharmaceutical Ass'n v. Klamath Medical Service Bureau*, 701 F.2d 1276, 1288-90 (9th Cir.

Under the standard adopted by these cases, the arrangement at issue here is not a tie-in. Operating rooms and anesthesia are used as a unit. The utility of one depends on the supply of the other. There is no market for operations without anesthesia; no patient thinks himself "coerced" if told that anesthesia comes with surgery; no patient has complained to the Hospital that he received an unwanted service. Moreover, operating rooms and anesthesia are packaged in fact, no matter how the hospital's medical staff is organized. A patient contracts for "surgery" and depends on the hospital or the surgeon to secure space, blood, oxygen, drugs, nurses, anesthesia, and the other essential ingredients of medical care. The hospital always excludes some potential suppliers deemed inferior to those admitted to practice. The patient inevitably sees the transaction as a package deal.[26] See, e.g., *United States*

1983); *Krehl v. Baskin-Robbins Ice Cream Co.*, 664 F.2d 1348 (9th Cir. 1982); *Principe v. McDonald's Corp.*, 631 F.2d 303 (4th Cir. 1980), cert. denied, 451 U.S. 970 (1981).

26. Respondent may reply that operating rooms and anesthesiology are separate products because they are priced separately on patients' bills. This cannot be the legal test of multiple products, though. A law firm prices partners' time, associates' time, and expenses separately, yet no one thinks of legal services as a tie-in. Hospitals price oxygen and blood separately, but no one would seriously argue that the joint provision of patients' rooms and oxygen is a tie-in. Hospitals' pricing practices are designed to fulfill the cost accounting and cost containment requirements of those (insurers and governmental agencies) who pay most bills and to encourage patients who pay their own charges to conserve in their demands on the hospitals' services. See *United States v. Jerrold Electronics Corp.*, 187 F. Supp. 545, 559 (E.D. Pa. 1960), aff'd mem. 365 U.S. 567 (1961) (package not a tie despite separate pricing). Cf. *Krehl, supra* (package not a tie despite fact that different parts were furnished by different entities).

v. American Society of Anesthesiologists, 473 F. Supp. 147, 160 (S.D.N.Y. 1979): "Anesthesiologists rarely have contact with patients prior to their surgery. . . . In fact, patients have little input into the selection of their anesthesiologists. . . . There is no evidence of competition between anesthesiologists insofar as patients are concerned; in fact, there is unrefuted evidence that the patient is not truly a customer of the anesthesiologist."

Because almost anything can be disassembled into components, the definition of a product is a matter more of convention than of logic. The only useful approach is to ask whether the particular aggregation threatens competition on the merits. If a given package is — as this one is — just a method by which the seller competes with other sellers, free to design their own packages, there is no reason for antitrust intervention.

Whether the judicial response to competitive package-selection is to say "one product" or to say "two products but lawful" is important because tie-in doctrine forces a two-product package to struggle under a substantial burden of justification. Putting firms to the task of providing this justification in litigation increases the costs of competition and, in the long run, reduces the amount of competition. We therefore agree with the Solicitor General's argument (US Br. in Support of Cert. 8-12) that whenever multiple sellers can compete by putting any items together in a package — when they can "Go ye and do likewise" — the case should be dismissed without further ado on the ground that there is but one "product." Under that standard, petitioners were entitled to judgment on the pleadings.

G. *The Anesthesiology Contract is not Different from an Ordinary Employment Contract*

The Solicitor General suggests that this case should be analyzed as a vertical exclusive dealing contract by which the Hospital obtains needed inputs. On this approach, the Rule of Reason applies, and the contract is sustained because the exclusive contract affects only a trivial fraction of the anesthesiology market.

We think the Solicitor General's analogy is not quite right. This case is about employment relations. The Hospital employs a staff of nurses. A freelance nurse cannot come into the Hospital and work with individual patients. A nurse who claimed an antitrust right to be employed by the Hospital, or to roam the halls waiting for physicians to designate patients for him or her to attend, would be laughed out of court. There is no good reason why the arrangement by which the Hospital secures anesthesiology services should be treated differently.

The arrangement by which the Roux anesthesiologists are retained is functionally equivalent to employment. They work full-time at the Hospital.[27] They are compensated at the Hospital's discretion. (They receive a fixed percentage of the anesthesiology department's revenue, but the Hospital has control of the department's charges. A. 25-27.) The device of an exclusive services contract is useful for purposes of the tax and pension laws. It also enables the Hospital to discharge the Roux group more easily than it could discharge

27. The fact that they may engage in limited teaching or outside practice (A. 25) does not undermine their status as employees. Full-time teachers sometimes engage in practice too.

regular employees (5-15 a.m. Tr. 60; 5-16 Tr. 161-63). We have emphasized that this right to dismiss Roux is an important source of competitive pressure.

For antitrust purposes, though, there is no difference between employment and the exclusive contract. No matter how the Hospital secures anesthesiologists, the patient seeking an operation is limited to the anesthesiologists the Hospital permits to practice there. Not everyone will be admitted, and the choice of anesthesiologists will be limited. That "vice," if vice it be, does not depend on whether the Hospital has four full-time anesthesiologists and a "closed" department or twelve part-time anesthesiologists and an open department. That doubtless explains why the plaintiff in this case is an anesthesiologist seeking employment rather than a patient complaining of enhanced prices.

Antitrust law has never been used to patrol employment opportunities. Even if Boeing employed half of all the aerospace engineers in the United States, it would be free to hire whom it wanted and turn others away. If Boeing instead chose to subcontract particular engineering tasks to outside firms, it need not run the antitrust gantlet. The losing bidders for the work would have had their competition. This case presents the same problem. There is *competition for the position* of being an anesthesiologist at the Hospital. Respondent competed and lost (5-16 Tr. 195). If the Hospital may hire anesthesiologists for indefinite periods, it may acquire anesthesia by contracts of indefinite duration.

The perspective we offer here is one in which the Rule of Reason, not the per se rule, supplies the governing standard. And because the employment market is at least as big as the nation, no firm has a monopoly or

monopsony. There is no possibility of market power, no possibility of harm to consumers. Whether these medical exclusive contract cases are filed as tie-in complaints, as boycott complaints (the physician claims that the rest of the physicians in the hospital are boycotting him by refusing to work with him), or as exclusive dealing cases (after the fashion of *Tampa Electric*), there is no need for litigation. If there is competition in the national employment market, which there always is, the plaintiff is destined to lose the case no matter how it is pleaded.

Defendants have won every exclusive medical contract case except this one. See note 8, *supra*. Many of the cases, including this one, have required extended proceedings and costly trials. If the plaintiff cannot win, summary judgment or dismissal on the pleadings is in order. *First National Bank of Arizona v. Cities Service Co.*, 391 U.S. 253, 289-90 (1968). Antitrust litigation is notoriously expensive, and "[i]t is a gratuitous cruelty to parties and their witnesses to put them through the emotional ordeal of a trial when the outcome is foreordained." *Mason v. Continental Illinois National Bank*, No. 81-2893 (7th Cir. Apr. 1, 1983), slip op. 10.

Although this case should have been dismissed under Fed. R. Civ. P. 12(b)(6) for failure to state a claim, it was nonetheless tried. The trial produced convincing evidence, and the district court found, that the contract did not restrain trade. With the per se rule out of the way, this case can be returned to the lower court for enforcement of the district court's judgment.

CONCLUSION

The judgment of the court of appeals should be reversed. The case should be remanded with instructions to affirm the district court's judgment in petitioners' favor.

Respectfully submitted.

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May 13, 1983

APPENDIX A

FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

OFFICE OF THE SECRETARY

February 24, 1983

Robert E. Nord, Esq.
Hinshaw, Culbertson, Moelman,
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Chicago, Illinois 60602

Dear Mr. Nord:

This is in response to your request for an advisory opinion concerning a contract by which Burnham Hospital has granted to a physician group the exclusive right to provide radiology services to patients in the hospital. You have asked whether any law enforced by the Commission would be violated if Burnham, acting pursuant to the contract, determines that a physician not affiliated with that group should not be given access to its radiology facilities or authorization to provide radiology services to Burnham's patients.

Based on the information you have supplied, it is the Commission's understanding that Burnham Hospital is a nonprofit general acute care hospital located in Champaign, Illinois. Among the services Burnham offers to the public are diagnostic radiology services. The hospital owns radiology laboratory facilities and employs approximately 20 radiology technicians. Throughout its history, Burnham has provided radiology services either through a radiologist employed by the hospital or a radiology group under exclusive contract with it.

You have explained that in 1980 the hospital, after receiving and considering proposals from other radiology groups, entered into a contract with a group of radiologists practicing under the name Prairie Professionals ("Prairie") that gives Prairie the exclusive right to operate the hospital's radiology laboratory and to render radiology services to patients at the hospital. Prairie is responsible for providing radiology services as needed; supervising and discharging the radiology technicians who are employed by the hospital; consulting with the hospital on the selection and replacement of equipment; and participating in educational and scientific activities at the hospital, including the training of radiology technicians. In addition, Prairie is to designate a radiologist to function as department chief, who will be responsible for operating the department and helping the hospital to control the department's budget. The contract has a term of three years; thereafter it is renewable for one-year periods and may be terminated by either party on 180-days notice. The hospital bills patients for the use of its radiology facilities. Prairie bills the patient separately for its professional services on a fee-for-service basis.

Prairie physicians are members of Christie Clinic ("Christie"), a large multispecialty physician group. Pursuant to a separate contract with Burnham, Christie purchased a full-body computed tomographic ("CT") scanner which it installed on hospital premises. Under the contract, Christie designates the physicians who may use the scanner.

You state that a physician has requested to practice radiology independently at Burnham notwithstanding the exclusive agreement with Prairie. Burnham would like to deny this physician access to its radiology facilities in order to adhere to, and retain the benefits of, the contract with Prairie.

According to your letter, Burnham believes that the contract is in the hospital's ecomonic interest and that it improves the quality of services provided at the hospital.

Specifically, the hospital believes that the contract creates cost efficiencies in procuring radiological services for its patients, operating and maintaining its equipment, and supervising its radiology technicians.

In addition to Burnham Hospital, there are three other general acute care hospitals in the Champaign-Urbana area from which Burnham draws patients. Burnham has 214 beds, Mercy Hospital has 255 beds, Carle Foundation Hospital has 281 beds, and Cole Hospital has 65 beds.[1] Thus, Burnham has about 26 percent of the beds in what Burnham describes as the relevant area. Carle is associated with a clinic, and only members of the clinic are permitted to have privileges at that hospital. Mercy and Cole each has an exclusive contract with a different group of radiologists; Carle has a closed staff in all its departments. The radiology contracts at both Cole and Burnham have changed hands in recent years.

Your letter states that Burnham offers no facilities or services not available in at least one of the other area hospitals. Both Carle and Burnham have full-body CT scans, the one at Burnham being owned by Christie Clinic rather than by the hospital. Both Carle and Mercy offer therapeutic radiological services that are not available at Burnham.

You also state that some Champaign-Urbana radiologists provide services to hospitals in surrounding communities. Radiology services are also available outside the hospital from independent radiology laboratories. Burnham accepts radiological studies from other hospitals or from independent laboratories at the discretion of the attending physician.

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[1] There are three other hospitals in the Champaign-Urbana area that do not seem to be in substantial competition with the four mentioned above. McKinley Memorial Hospital has 31 beds and is affiliated with the University of Illinois. Herman Adler Mental Health Center is a state-run long-term care facility for children with 46 beds. The hospital at Chanute Air Force Base has 55 beds, but apparently is not open to the general public.

Antitrust analysis of hospital exclusive contracts can be complicated because the contracts create relationships among hospitals, physicians, and patients that have no clear parallels in commercial practice and that are difficult to characterize. The contract occurs at one level — between the hospital and the physician — while the direct financial transaction occurs at a different level — between the physician and the patient, with payment usually made by an insurer. Some court decisions suggest that in analyzing exclusive contracts the patient should be considered the buyer and the hospital and the physician group the sellers of the service in question.[2] Another court has suggested that the hospital rather than the patient should be considered the buyer of the service, and the physician group the seller, in cases where the patient generally does not make a personal decision to obtain the service and does not personally select the provider.[3] The Commission is of the opinion that each approach may be helpful in some circumstances, because exclusive contracts may affect both competition among physicians and hospitals for patients and competition among physicians to market their services to hospitals. Accordingly, antitrust analysis should be flexible enough realistically to take into account the impact of these contracts on hospitals, physicians, and patients.

An exclusive contract for radiology services can have both procompetitive and anticompetitive aspects. The contract grants exclusivity within the hospital to a particular radiologist or group of radiologists and thereby limits the ability of the patient and the attending physician to choose among competing radiologists. It may also, if radiologists

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[2] Robinson v. Magovern, 521 F. Supp. 842, 885 (W.D. Pa. 1981), *aff'd mem.*, 688 F.2d 842 (3d Cir. 1982), *cert. denied*, 51 U.S.L.W. 3340 (U.S. Nov. 1, 1982) (No. 82-415); Hyde v. Jefferson Parish Hosp. Dist. No. 2, 513 F. Supp. 532 (E.D. La. 1981), *rev'd on other grounds*, 686 F.2d 286 (5th Cir. 1982), *petition for cert. filed*, No. 82-1031 (Dec. 17, 1982).

[3] Dos Santos v. Columbus-Cuneo-Cabrini Medical Center, 684 F.2d 1346 (7th Cir. 1982).

contract in groups, make it more difficult for individual physicians to enter the market since a physician may have to join an existing group or form a new group in order to practice in the area.

A contract of reasonable duration does not, however, eliminate competition among radiologists or prevent entry. Instead, it shifts the focus of competition among both established and entering radiologists to the securing of the contract. The exclusive contract may also have procompetitive effects by providing a number of benefits to hospitals and to their patients. There is reason to believe that in some circumstances at least, the use of exclusive contracts in certain hospital departments can facilitate efficient delivery of services in a number of ways. It can increase the hospital's control over operation of the department, ensure full-time availability of services, lower costs through standardization of procedures and centralized administration of the department, permit better scheduling of the use of facilities, facilitate maintenance of equipment, improve supervision of support staff and working relationships between the staff and physicians, and improve the quality of services by assuring that physicians perform enough procedures to maintain their proficiency, have an incentive to upgrade their skills, and are effectively subject to hospital standards of quality.[4] To the extent that these objectives are realized, a hospital is better able to compete with other hospitals.

Hospitals must assure that radiology services are available as needed and of acceptable quality if they are to attract attending physicians and their patients. When the decision to use an exclusive contract to staff a hospital-based department is made unilaterally by a hospital in order to promote efficient operation of the department, when the hospital lacks significant power in the relevant market, and when the

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[4] *See, e.g.*, Foster, *Exclusive Arrangements Between Hospitals and Physicians: Antitrust's Next Frontier in Health?*, 26 St. Louis U.L.J. 535, 540-41 (1982); M. Thompson, *Antitrust and the Health Care Provider* 151-52, 154 (1979).

contract is of reasonable duration or terminable by the hospital on reasonable notice, the contract would not generally be likely to have a substantial anticompetitive effect in any market.[5]

Several courts considering antitrust challenges to exclusive contracts for hospital services have treated the agreements as vertical restraints subject to rule of reason analysis.[6] In balancing the procompetitive and anticompetitive effects of the contracts in the hospital and physician services markets, the courts have considered such factors as the characteristics of the market, particularly the market power of the hospital in question; the purpose of the contract; its duration; the manner in which the decision was made to use an exclusive arrangement; and the procompetitive benefits of the contract. These courts have not found that the exclusive contracts considered had significantly anticompetitive effects, and they have found that the contracts resulted in significant competitive benefits to the hospitals.

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[5] A different case would be presented if the hospital joined a conspiracy among members of the medical staff to restrain competition among hospital-based physicians. *See* Robinson V. Magovern, 521 F. Supp. 842, 906 (W.D. Pa. 1981), *aff'd mem.*, 688 F.2d 824 (3d Cir. 1982), *cert. denied*, 51 U.S.L.W. 3340 (U.S. Nov. 1, 1982) (No. 82-415); State of Maryland v. The Medical Staff of Harford Memorial Hospital, Circuit Court for Harford County, Equity No. 27734 (Oct. 29, 1981) (assurance of discontinuance obtained from hospital staff that allegedly threatened to refuse to deal with any but a specified group of radiologists in an attempt to coerce the hospital into contracting with the group on terms demanded by it). In addition, different questions would be raised under the antitrust laws if a large proportion of the specialists in a market formed a group and negotiated jointly with a number of hospitals in the area.

[6] Hyde v. Jefferson Parish Hosp. Dist. No. 2, 513 F. Supp. 532 (E.D. La. 1981), *rev'd*, 686 F.2d 286 (5th Cir. 1982), *petition for cert. filed*, No. 82-1031 (Dec. 17, 1982); Smith v. Northern Michigan Hospitals, Inc., 518 F. Supp. 644 (W.D. Mich. 1981), No. 81-1513 (6th Cir. argued Oct. 21, 1982). *See also* Dos Santos v. Columbus-Cuneo-Cabrini Medical Center, 684 F.2d 1346 (7th Cir. 1982); Robinson v. Magovern, 521 F. Supp. 842 (W.D. Pa. 1981), *aff'd mem.* 688 F. 2d 824 (3rd Cir. 1982), *cert. denied*, 51 U.S.L.W. 3340 (U.S. Nov. 1, 1982) (No. 82-415).

One recent decision, however, held that an exclusive contract for anesthesia services constituted a per se illegal tying arrangement. *Hyde v. Jefferson Parish Hospital District No. 2*, 686 F.2d 286 (5th Cir. 1982), *petition for cert. filed*, No. 82-1031 (Dec. 17, 1982). The court in that case construed the contract as tying the sale of the hospital's chosen anesthesia service to the use of its operating rooms, found that the hospital had appreciable economic power in the township in which it was located, and concluded that the contract restrained, and indeed eliminated, competition among anesthesiologists in the hospital.

The Commission is of the opinion that the per se rule of illegality for tie-ins is not applicable to Burnham's contract with Prairie Professionals. Although radiology services are physically separable from other services and facilities supplied by Burnham, mere separability is not a sufficient basis for characterizing an arrangement as a tie-in. Instead, the function of the aggregation must be examined to see if the restraint represents the forced purchase of a second distinct commodity to leverage power from one market to another in order to avoid competition on the merits.[7] The purposes and effects of the contract in question are very different from such a classic tie. Rather than avoiding competition on the merits, Burnham is attempting to compete with other hospitals by obtaining efficiencies and a desired level of quality and service in its radiology department, according to the submission. Using a form of vertical integration to combine functionally related services, the hospital is apparently seeking to improve the array of health care services that it offers to the public. Moreover, the case law indicates that no tie-in should be found to exist where, as here, the hospital derives

[7] *See* Times-Picayune Publishing Co. v. United States, 345 U.S. 594, 614 (1953); Hirsh v. Martindale-Hubbell, Inc., 674 F.2d 1343 (9th Cir. 1982), *cert. denied*, 51 U.S.L.W. 3340 (U.S. Nov. 1, 1982) (No. 82-570); Krehl v. Baskin-Robbins Ice Cream Co., 664 F.2d 1348 (9th Cir. 1982); Principe v. McDonald's Corp., 631 F.2d 303 (4th Cir. 1980), *cert. denied*, 451 U.S. 970 (1981).

no direct or exploitative financial benefit from requiring that all diagnostic radiology services in the hospital be provided by a particular group of physicians.[8] In short, the contract is not the type of pernicious, naked restraint of trade to which the per se rule of illegality applies.

The Commission believes that Burnham's contract is most closely analogous to a requirements contract, a type of exclusive dealing arrangement, that should be judged under the rule of reason in a fashion similar to that for more traditional vertical restraints.[9] The Commission's analysis of the contract focuses on whether its effects on competition among radiologists and among hospitals are on balance harmful or beneficial. Factors relevant to the analysis include the proportions of the hospital and physician services markets involved in the contract, the purposes of the contract, its duration, the extent to which it deters entry, the benefits the hospital and the public derive from it, and the extent of competition for the contract.[10]

Based on the information available to the Commission, it does not appear on balance that Burnham's adherence to its contract with Prairie Professionals would violate the Federal Trade Commission Act or any other law enforced by the Commission. You report that the contract was intended to, and does, facilitate efficient operation of the radiology department. The Commission understands that the decision

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[8] *See, e.g.*, Boddicker v. Arizona State Dental Ass'n, 1982-2 Trade Cas. (CCH) ¶64,812 (9th Cir. March 24, 1982); Keener v. Sizzler Family Steak Houses, 597 F.2d 453 (5th Cir. 1979); Kentucky Fried Chicken Corp. v. Diversified Packaging Corp., 549 F.2d 368 (5th Cir. 1977); Rodrique v. Chrysler Motor Corp., 421 F. Supp. 903 (E.D. La. 1976); Crawford Transport Co., Inc. v. Chrysler Corp., 338 F.2d 934 (6th Cir. 1964); Rumple v. Bloomington Hospital, 422 N.E. 2d 1309 (Ind. App. 1981).

[9] *See* Tampa Electric Co. v. Nashville Coal Co., 365 U.S. 320 (1961); Twin City Sportservice Inc. v. Charles O. Finley & Co., 676 F.2d 1291 (9th Cir. 1982), *cert. denied*, 51 U.S.L.W. 3354 (Nov. 8, 1982).

[10] *See* Beltone Electronics Corp., FTC Docket 8928, slip op. at 34 (July 6, 1982).

to enter into the contract, and thus to deny radiology privileges to other physicians, was made unilaterally in the interest of the hospital, and was neither coerced by members of the medical staff nor taken in furtherance of a combination between the hospital and the medical staff or any of its members to restrain competition among physicians. Burnham competes with at least three other hospitals, and does not occupy a dominant position in the market. It is not a unique facility. The contract has an initial term of three years with one-year extensions thereafter, and is terminable on 180-days notice by either party. Thus, opportunities for competition among radiology groups to secure the contract are preserved, and there is evidence that some competition for contracts does occur. In addition, radiology can be practiced to at least some extent on an outpatient basis, and Champaign-Urbana radiologists apparently have some access to hospitals in the surrounding area. In addition, there is no reason to believe that effectuation of the contract would result in higher prices for radiology services. Based on these factors, it appears that the contract does not unreasonably restrict competition among radiologists and that it may facilitate competition among hospitals.

Based on its understanding of the facts surrounding the decision to enter into the exclusive contract and the planned denial to other applicants of the right to practice radiology in the hospital, pursuant to that contract, as those facts are outlined above and further detailed in your submission, it is the Commission's opinion that Burnham Hospital's adherence to its grant to Prairie Professionals of the exclusive right to offer radiology services at the hospital would not violate the Federal Trade Commission Act or any other statute enforced by the Commission.[11]

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[11] By responding to Burnham's request for an advisory opinion concerning the described facts, the Commission takes no position on the presence or absence of any or all of the jurisdictional prerequisites to a law enforcement proceeding under Section 5 of the FTC Act, 15 U.S.C. § 45.

This advisory opinion, like all those issued by the Commission, is limited to the proposed conduct described in the petition being considered. Because by necessity it is based on factual representations by the hospital, it does not constitute approval of action taken by the hospital on any specific application for privileges that may become the subject of litigation before the Commission or any court, when those facts may be controverted. The conclusions stated in this letter are based on the Commission's understanding of present market conditions in the Champaign-Urbana area and in the health care field generally. The Commission retains the right to reconsider the questions involved or to rescind or revoke its opinion if the public interest so requires in accordance with Section 1.3(b) of the Rules of Practice.

By direction of the Commission.

BENJAMIN I. BERMAN
Acting Secretary

APPENDIX B
Local Hospital Statistics

Jefferson and Orleans Parish Hospitals Located on the "East Bank" (1)	Total Admissions (2)	Admissions from Jefferson and Orleans Parish (2)	Number of Beds (3)	Average Daily Census (3)
1. Charity	22,028	16,114	1,125	832
2. Southern Baptist	8,889	3,728	603	474
3. Ochsner Foundation	8,236	3,557	531	413
4. EAST JEFFERSON GENERAL	8,211	6,735	440	353
5. Touro Infirmary	8,132	6,822	509	395
6. Pendleton Memorial Methodist	6,328	3,834	318	211
7. Hotel Dieu	5,253	3,903	323	254
8. Lakeside	4,915	3,719	209	141
9. Veterans Administration	4,162	2,564	467	397
10. Mercy	4,063	3,363	240	195
11. Tulane Medical Center	N/A	N/A	235	190
12. St. Charles General	2,696	2,055	168	139
13. Flint-Goodridge	1,745	1,689	113	N/A
14. St. Claude General	1,698	1,583	136	81
15. Eye & Ear Institute	1,606	1,011	71	N/A
16. Montelepre Memorial	958	828	64	49

Local Hospital Statistics (continued)

Jefferson and Orleans Parish Hospitals Located on the "East Bank" (1)	Total Admissions (2)	Admissions from Jefferson and Orleans Parish (2)	Number of Beds (3)	Average Daily Census (3)
17. Children's	951	597	105	61
18. New Orleans Mental Health	488	363	237	165
19. Metairie	476	418	84	N/A
20. Coliseum House	156	99	168	140
21. River Oaks	93	44	85	69
22. US Public Health	N/A	N/A	N/A	N/A
SUBTOTAL	91,084	63,026	6,231	4,559
East Jefferson Percentage	9.0%	10.7%	7.1%	7.7%
"Top Four" Percentage	52.0%	53.3%	44.4%	46.4%
Herfindahl-Hirschman Index	1,096	1,137	[illegible]	872
Other Hospitals in New Orleans Metropolitan Area (SMSA) (1)				
23. West Jefferson	9,160	7,846	403	332
24. JoEllen Smith	4,383	3,789	336	174
25. Slidell Memorial	3,745	69	182	N/A

Local Hospital Statistics (continued)

Other Hospitals in New Orleans Metropolitan Area (SMSA) (1)	Total Admissions (2)	Admissions from Jefferson and Orleans Parish (2)	Number of Beds (3)	Average Daily Census (3)
26. Tammany	2,856	26	160	121
27. Chalmette	1,617	158	109	91
28. Southeast Louisiana	1,172	573	493	423
29. Highland Park	N/A	N/A	96	N/A
30. South Jefferson	704	604	75	23
31. St. Bernard	357	45	39	N/A
TOTAL	115,078	76,136	8,144	5,723
East Jefferson Percentage	7.1%	8.9%	5.4%	6.2%
"Top Four" Percentage	42.0%	49.3%	34.0%	37.8%
Herfindahl-Hirschman Index	785	911	564	658

Note: N/A = Not Available.

(1) Source: Ex. D-5 (New Orleans area hospital identification and locations).

(2) Admission data are for the period November 1, 1978 to April 30, 1979. Source: Ex. D-7.

(3) Source: American Hospital Assoc., *American Hospital Association Guide to the Health Care Field*, pp. A-91 to A-96 (1982).

NO. 82-1031

Office-Supreme Court, U.S.
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JUL 7 1983
ALEXANDER L. STEVAS

In the Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 and EAST JEFFERSON HOSPITAL BOARD,

PETITIONERS

V.

DR. EDWIN G. HYDE,

RESPONDENT

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE RESPONDENT

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QUESTION PRESENTED

Whether a public hospital possessing market power creates an illegal tying arrangement when it compels users of the hospital's surgical facilities to purchase anesthesia services from a professional corporation of anesthesiologists with which the hospital has a contractual agreement to share fees.

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BRIEF FOR THE RESPONDENT

STATEMENT OF THE CASE

This action was brought by the respondent, Dr. Edwin G. Hyde ("Dr. Hyde") for declaratory and injunctive relief concerning his exclusion from the medical staff at East Jefferson General Hospital ("the Hospital"),[1] a public facility located in Jefferson Parish, Louisiana. Dr. Hyde's application for appointment to the medical staff

[1] For convenience, this brief sometimes also will refer to the petitioners, Jefferson Parish Hospital District No. 2 ("the District") and East Jefferson Hospital Board ("the Board") collectively as "the Hospital."

was denied solely because the Hospital had entered into an "exclusive" contract with another group of anesthesiologists named Roux and Associates. (Pl. Ex. 6; R. 26-27, 94).[2] Dr. Hyde asked the district court to declare that his exclusion from the medical staff was illegal for several reasons,[3] including that it violated Section 1 of the Sherman Act. Dr. Hyde contended that the Hospital's actions violated the Sherman Act either under the Rule of Reason (A., 8-9), or as a per se illegal tying arrangement in that users of the Hospital's surgical facilities (the tying product) also were compelled to purchase anesthesia services (the tied product) from Roux & Associates. (A., 8).

Following a trial, the district court entered Findings of Fact and Conclusions of Law denying all of Dr. Hyde's claims. *Hyde v. Jefferson Parish Hospital District No. 2*, 513 F.Supp. 532 (E.D. La. 1981). The court of appeals reversed, holding that the Hospital's exclusive contract with Roux & Associates created a tying arrangement that was illegal per se. *Hyde v. Jefferson Parish Hospital District No. 2*, 686 F.2d 286 (5th Cir. 1982).[4]

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[2] The trial record contains three volumes; however, only two of the volumes are numbered. This brief will use the following trial record references:

Testimony of Mose Ellis on May 15, 1980—"R."

Other testimony on May 15, 1980—"R., Vol. I."

All testimony on May 16, 1980—"R., Vol. II."

[3] Only Dr. Hyde's Sherman Act claim is before this Court.

[4] The court of appeals also held that Dr. Hyde was entitled to an injunction requiring the Board to appoint him to the Hospital's medical staff. 686 F.2d at 294. As the Hospital did not seek a stay from the court of appeals' mandate, the district court issued the injunction on April 26, 1983. The Board appointed Dr. Hyde to the Hospital's medical staff on May 24, 1983.

1. *The Hospital.*

The Hospital is owned and operated by the District, which was created pursuant to Louisiana law by Jefferson Parish, Louisiana as a political subdivision of the state. (Pl. Ex. 1; R., 7, 94). The geographic boundaries of the District encompass only that part of Jefferson Parish located on the East Bank of the Mississippi River. (*Id.*). The portion of Jefferson Parish located on the West Bank of the Mississippi River is served by a separate public hospital, known as West Jefferson General Hospital. (*Id.*). According to its enabling legislation, the purpose of the District is to own and operate hospitals within the District and to provide hospital and other health services to the residents of the District. La. R.S. 46:1052.

As the Hospital is the only public hospital located on the East Bank of Jefferson Parish (R., 7), it draws patients primarily from that area. Evidence at trial showed that over seventy percent of the patients admitted to the Hospital live within the geographic boundaries of the District. (A., 50). The same evidence showed that the Hospital captures approximately thirty percent of all residents of the District who are admitted to any hospital. (A., 49).

The Board was appointed by the Jefferson Parish Council pursuant to state law to govern the operation of the District. (R., 8). The board is directed by statute "[t]o represent the public interest in providing hospital and medical care in the district." La. R.S. 46:1055. One of the Board's specific functions is to make appointments to the Hospital's medical staff "upon the recommendations of the physicians who are authorized to practice within the hospital." La. R.S. 46:1058.

2. *The Hospital's medical staff.*

The Hospital's medical staff is organized as an entity separate and apart from the Hospital itself. (R., 9-10). The medical staff has enacted and is governed by its own by-laws, and it elects its own offices and committees. (R., 10).

The medical staff by-laws (Def. Ex. 2; R., Vol. I, 55, 56) place primary responsibility on the medical staff for the quality of patient care. Membership on the medical staff is limited to physicians "who are located closely enough to the hospital to provide continuous care to their patients, and who assume all the functions and responsibilities of membership on the active medical staff: including emergency service care and consultation arrangements." (*Id.* at 4). Initial appointments to the medical staff are provisional (*Id.* at 6) and can be made by the Board only upon recommendation of the existing staff. (*Id.* at 3). Before it makes any recommendation regarding an applicant, the medical staff, through a credentials committee, must examine the applicant's "character, professional competence, qualifications and ethical standing" and "determine, through information contained in references given by the practitioner and from other sources available to the committee, including an appraisal from the clinical department in which privileges are sought, whether the practitioner has established and meets all of the necessary qualifications...." (*Id.* at 7). Each staff member is subject to annual review and reappointment (*Id.* at 10-11). The medical staff may take corrective action at any time when "the activities of professional conduct of any practitioner with clinical privileges are considered to be lower than the standards or aims of the medical staff as to be disruptive to the operations of the hospital." (*Id.* at 14).

3. *Dr. Hyde's application.*

Dr. Hyde submitted an application for appointment to the Hospital's medical staff on July 14, 1977 (A., 29-33). Pursuant to the medical staff by-laws, the application was reviewed by the medical staff credentials committee, which recommended Dr. Hyde's appointment. The medical staff executive committee also reviewed the application and submitted a recommendation to the Board that the application be approved. (R., 14-17).

In spite of the medical staff's favorable recommendations, the Board voted on October 18, 1977 to deny Dr. Hyde's application. (R., 21-23). Dr. Hyde was notified of the Board's decision by letter from the Hospital's executive director stating that the application had been denied "in view of the exclusive nature of the contract between the hospital and Roux & Associates and due to the fact that we have no openings in the Department of Anesthesia." (Pl. Ex. 6; R., 26-27, 94). The Hospital's executive director, Mose Ellis, explained at trial that his statement that there were "no openings in the Department of Anesthesia" meant only that Roux & Associates did not intend to employ Dr. Hyde. (R., 27-28).

4. *The exclusive contract.*

Before the Hospital opened its doors in 1971, the Board reached a decision to enter into an exclusive contract with one anesthesiologist. According to the two Board members who testified at trial, the members of the Board believed that an exclusive contract was necessary in order to attract an anesthesiologist to a new hospital with no track record. Dr. John C. Rourke described the situation in this way:

> First, we have to cast ourselves back into the situation we're in back in 1970. We had an empty building sticking up there in the sky in the middle of a drain [sic] swamp, which had never been a hospital before, and we had a new, untried, untested venture. And we had to build from scratch. We were not overwhelmed with eager people looking for the various jobs in the hospital base specially [sic].
>
> I know that this trial is about anesthesiologists, but in my own recollection of the period, we had four separate jobs to fill. Anesthesiology was one of them. And in two of the areas, we had to really persuade people, Come on in and give us a try. It was an unopened book. We had no fiscal experience. They had to cast in their lot with us and take the chance that we would be a success. In anesthesia—Well, we felt that each department of the four departments only required one man to get it started. And even some of those men applicants were unsure whether they would be able to make a living at it. It was an untested venture. So, we were looking for one good man in each area to come in to cast—tie his future to ours, work with us and build a department.

(R., Vol. II, 149-50). Nickolas Gagliano, a member of the initial Board and chairman of the Board at the time of trial, expressed similar sentiments. Mr. Gagliano said: "I doubt very much if Dr. Roux or anybody else, Dr. Hyde included would have come to our hospital if we didn't give them what you call a monopoly." (R., Vol. II, 195).

The initial contract between the Hospital and Roux & Associates (A., 18-22), executed in February, 1971, provided that "[t]he Hospital shall restrict the use of its anesthesia department to Roux & Associates and no other

persons, parties or entities shall perform such services within the Hospital for the terms of this Contract." (A., 19). When a second contract (A., 23-28) was executed in January, 1976, the provision was deleted at the request of Roux & Associates' president, Dr. Kermit Roux. At trial, Dr. Roux explained the reason for his request.

> Q. The Judge asked you if in fact when the 1976 contract was negotiated and executed, you asked that language calling for the exclusion of other anesthesiologists be deleted from the contract. .
>
> A. Yes, sir.
>
> Q. So that it would no longer be a part of the contract?
>
> A. Yes, sir. The reason we did that, there were a number of reasons. There was this other group that had requested to come practice there and led us to believe that some physicians preferred them to give their anesthetics. And if that were true, then I think that they should be allowed to practice.
>
> The other reason is pretty much what you have alluded to, I didn't want to be there on the basis of hiding behind a contract. If I couldn't provide the service as best I could, then someone else ought to have a shot at it.
>
> And I have been told by people a number of times that, you're hiding behind the contract because it gives you "exclusive privileges" and doesn't let anyone else come. And I don't believe that that's the way medicine should be practiced. It should be practiced on the basis of the person whom the physician or the patient feels can do the best job, should be their physician.

> So, we finally got them to delete that part of the contract.

(R., Vol. I, 7-8).

Although Dr. Roux obtained a change in the language of the 1976 contract because he felt it was wrong to exclude another qualified physician from the medical staff, the Hospital interpeted the 1976 contract as continuing to require the exclusion of all other anesthesiologists. Mr. Ellis testified that another provision, which remained in the 1976 contract, had the same effect as the provision deleted. (R., 37-38).

Both the 1971 contract and the 1976 contract prohibited Roux & Associates from providing anesthesia services at other hospitals. (A., 19, 25; R., 38-39).[5] However, during 1977, at least two of the three anesthesiologists then employed by Roux & Associates routinely traveled to Lakeside Hospital, located nearby, to handle cases. (R., Vol. I, 23-24). Mr. Ellis acknowledged that he had been informed of this apparent contractual breach by Roux & Associates, but testified that he did "nothing about it." (R., 40-41). According to Mr. Gagliano, it took a special ad hoc committee of the Board to persuade Roux & Associates to confine its practice to the Hospital (R., Vol. II, 176-79).

The anesthesia charge billed to each patient at the Hospital was determined by Roux & Associates according to the length and complexity of the procedure performed.[6]

---

[5] The 1976 contract did permit Roux & Associates to engage in "teaching, research and limited consultative activities...other than on the Hospital premises." (A., 25). However, Mr. Ellis testified that this contract provision "[w]ould not allow them to do very much." (R., 39).

[6] Although the 1976 contract provided that "the Hospital shall

The total charge billed to a patient included a "professional component," intended to cover the actual services of the anesthesiologist, and a "hospital component," intended to cover related services and supplies furnished by the Hospital. (R., 82-83; R., Vol. I, 26). The patient was charged separately by the Hospital for drugs and medicines used in connection with the anesthesia procedure. (A., 27; R., 83).[7]

The Hospital collected payment from each patient and, at the end of each month, it remitted to Roux & Associates fifty percent of all receipts, less an eight percent deduction for bad debts, charity and other write-offs. (A., 26-27; R., 84-85). The fifty percent share retained by the Hospital was a negotiated figure that was unrelated to the Hospital's actual costs. (R., 85-86). Thus, under the 1976 contract, both the Hospital and Roux & Associates received a fifty percent share of each patient's total anesthesia charge irrespective of the length and complexity of the procedure or of the nature of the professional and hospital services actually rendered.

The Hospital derived a substantial (and increasing) profit from its financial arrangement with Roux & Associates. (A., 51). The anesthesia fees retained by the Hospital substantially exceeded the costs it incurred in maintaining and operating the department of anesthesio-

---

(Footnote 6 continued)
establish the amounts to be charged to patients for services rendered in the Hospital's department of anesthesia" (A., 26), in practice the Hospital permitted Roux & Associates to determine the charge. Mr. Ellis testified: "The hospital personnel do not compute this charge. We allow the M.D. anesthesiologists to compute that charge that goes on the patient's bill." (R., 84).

[7] Although Roux & Associates now bills its patients directly for its services, the Hospital continues to bill for related services, supplies, drugs and medicines furnished by it.

logy. (*Id.*; R., 88-93).

5. *The relationship between anesthesiologists and nurse anesthetists.*

The Hospital's major expense in operating the department of anesthesiology was the compensation paid to the nurse anesthetists whom it employed to work with Roux & Associates.[8] Under the 1976 contract, the Hospital was required to employ all nurse anesthetists, but their selection was subject to the approval of Roux & Associates. (A., 24).[9]

At the time of trial, at least one nurse anesthetist was assigned to each of the Hospital's thirteen operating rooms and the four (three at the time of Dr. Hyde's application for admission to the staff) anesthesiologists employed by Roux & Associates traveled from room to room as they were called upon for supervision. (R., Vol. I, 29-31; R., Vol. II, 4-7). The anesthetic given to a patient normally was administered by a nurse anesthetist; an anesthesiologist remained with a patient only for the more complicated operations. (*Id.*) In routine cases, nurse anesthetists might in fact make the decision as to what anesthetic to administer and might administer an anesthetic without any direct supervision at all. (R., Vol. I, 75-78).

All of the anesthesiologists who testified at trial agreed that nurse anesthetists remain necessary in Loui-

[8] Roux & Associates now employs and compensates the nurse anesthetists directly.

[9] Dr. Hyde employs his own nurse anesthetists at Lakeside Hospital and he testified that, except for obstetric cases, he would continue to do so upon being admitted to the Hospital's medical staff. (R., Vol. II, 63, 78-79).

siana because there are not enough M.D. anesthesiologists available. (R., Vol. I, 12, 82-83; R., Vol. II, 44-45).[10]

6. *The impact of exclusive contracts on patient care.*

All of the physicians who testified at trial agreed that a patient or surgeon should be free to choose an anesthesiologist based on an evaluation of his or her ability and competence. (R., Vol. I, 34-36, 64-65; R., Vol. II, 29, 157-58). Relying on its exclusive contract with Roux & Associates, the Hospital admittedly denied this freedom of choice to both patients and surgeons. (R., 72-73).

There also was undisputed testimony that the exclusion of competition in the practice of anesthesiology tends to reduce the incentive for medical improvement or innovation. Dr. John Adriani, an internationally recognized expert in the training of anesthesiologists and the practice of anesthesiology (A., 52-76), described how the absence of intrahospital competition among anesthesiologists can affect the quality of patient care delivered:

> Q. Doctor, in your opinion, does the closed staff arrangement have a general effect on the quality of care given the patient in a general sense?
>
> A. Yes. And I think having a closed staff creates a monopoly. And it wants [should be "thwarts"] competition among physicians.
>
> Q. You're saying then that the competition would improve or is beneficial to the delivery of patient care?

[10] At the time of trial, there were only about 156 anesthesiologists available to service the approximately 345 hospitals in the state. (R., Vol. I, 73).

> A. Yes, it is. A good example of that is at the Baptist Hospital. There was one group in there and a second group just formed in the last several years. And the original group wouldn't do certain procedures. For instance, they were not interested in doing the particular block that we call epidural block. This other group came in and started to do them, and so then the other group started doing them. So, as a result, the patients are getting better care and getting a wider variety of anesthesiology than they did originally.

(R., Vol. II, 30).

In addition to stifling medical innovation, the evidence indicated that exclusive contracts encourage hospitals, for financial reasons, to employ a greater number of nurse anesthetists to the exclusion of M.D. anesthesiologists. Nurse anesthetists are trained and utilized by anesthesiologists only because of the shortage of anesthesiologists. (R., Vol. I, 12, 82-83; R., Vol. II, 44-45). A nurse anesthetist is not a physician and is trained to work only under the supervision of an anesthesiologist. (R., Vol. II, 22-23). Furthermore, there are practical limits to the number of nurse anesthetists that an anesthesiologist can supervise properly. (R., Vol. II, 31-32, 41). However, because hospitals realize a profit by hiring their own nurse anesthetists and splitting anesthesia fees with a small contract group of anesthesiologists (R., Vol. II, 36-38), they have an incentive to make the ratio of nurse anesthetists to anesthesiologists as large as possible (R., Vol. II 32-33).

7. *The impact of exclusive contracts on competition among anesthesiologists.*

An anesthesiologist normally is selected by the

surgeon rather than the patient based on a familiarity gained through a working relationship. (R., Vol. II, 26-27). However, a surgeon cannot develop a familiarity with an anesthesiologist unless there is an initial opportunity for them to work together (R., Vol. II, 27-28). The Hospital's exclusive contract with Roux & Associates precluded any surgeon using the Hospital's operating rooms from selecting and working with any anesthesiologist other than a member of Roux & Associates.

In some instances, patients do ask for a particular anesthesiologist. (R., Vol. I, 87-88; R., Vol. II, 28-29). Moreover, the nature of Dr. Hyde's practice makes it much more likely that patients will request his services. Approximately fifty percent of Dr. Hyde's work involves the subspeciality of obstetric anesthesia and, more particularly, the administration of epidural anesthetics. (R., Vol. II, 61-64, 72-73).[11] Due to the nature of his subspecialty, Dr. Hyde's relationship with his obstetric patients is more personal than the usual relationship between an anesthesiologist and a patient. (R., Vol. II, 73-74). As a result, it is not uncommon for an obstetric patient to request specifically that Dr. Hyde, or one of his associates, serve as her anesthesiologist. (R., Vol. II, 74). An obstetric patient at the Hospital, however, would have been refused if she had requested Dr. Hyde's services. (R., 72-73).

Exclusive contracts also tend to limit the total number of anesthesiologists available to serve patients in the market. Although there is an admitted shortage of anesthesiologists in the market area,[12] anesthesiologists

[11] Epidural anesthetics are administered by anesthesiologists rather than nurse anesthetists. (R., Vol. II, 64).

[12] This would be true regardless of the geographic market definition.

who do not have exclusive arrangements with hospitals are forced to look elsewhere for practice opportunities. (R., Vol. II, 30-31, 33, 92-95). In addition, medical students who wish to remain in the area to practice are discouraged from entering the specialty of anesthesiology because of the difficulty they will have in finding employment. (R., Vol. II, 31).

8. *The decisions of the lower courts.*

The district court found that the Hospital's exclusive contract with Roux & Associates created a tying arrangement in that surgical facilities and anesthesia services are separate products. 513 F.Supp. at 542. The court also found that the exclusive contract restrained competition among anesthesiologists. *Id.* at 541. However, the district court declined to hold the exclusive contract illegal per se for two reasons. First, the court opined "that the per se rules used in antitrust cases governing regular commercial activities should not be made automatically applicable to cases involving professional activities." *Id.* at 542. In support of this view, the court cited footnote 17 of *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975).[13] *Id.* at 543. Second, the district court held that Dr. Hyde failed to show that the Hospital "dominated" the relevant geographic market for surgical facilities. 513 F.Supp. at 542-43.

The market which the district court concluded the Hospital did not dominate was defined by the court to include at least the East Bank of both Orleans and Jefferson

[13] The Hospital apparently no longer contends (as it did in the district court) that it should be exempted from the rules of per se illegality. See Brief for the Petitioners, 4 n. 3. Therefore, we will review here only the district court's second ground for holding that the exclusive contract was not per se illegal.

Parishes, Louisiana. *Id.* at 540. Although the court acknowledged that patients have a natural preference for hospitals near their homes,[14] it apparently did not consider this fact in determining the relevant geographic market.[15] The only evidence cited by the district court in support of its market definition was that "[s]eventy per cent (70%) of the patients living in East Bank Jefferson Parish go to hospitals other than East Jefferson." *Id.*

Having defined the market to include the East Bank of both Jefferson and Orleans Parishes, the district court concluded that a per se violation had not been proven because "[t]here was no evidence that East Jefferson was a dominant economic power in the market in which it competes." *Id.* at 541.

While the case was awaiting argument in the court of appeals, the Board declared the Hospital's department of anesthesiology to be "open" and moved to dismiss the appeal as moot.[16] Dr. Hyde opposed the motion and it was

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[14] The district court stated:

> It is likely that any individual will choose to go to the hospital closest to his home if it is possible to do so for the convenience of the family. Persons living nearer to hospitals in other areas will choose to go to those hospitals if possible.

513 F.Supp. at 543.

[15] The court stated that it did "not find this factor is proof that East Jefferson is a strong economic power in the market in which it competes." 513 F.Supp. at 543. Thus, the district court apparently considered the preference for nearby hospitals only as an indication of market power, not as an indication of the market itself.

[16] Although the Hospital now claims that the "opening" of the department of anesthesiology resulted merely from the expiration of the 1976 contract (Brief for the Petitioners, 6), in its motion to dismiss it represented that the "opening" resulted from a policy change on the

denied by the court of appeals. (A., 79). Although Dr. Hyde did not accept the Hospital's invitation (A., 77-78) to reapply for medical staff membership, he did obtain from the district court on April 26, 1983 an injunction ordering the Board to admit him to the medical staff without further delay.[17] On May 24, 1983, the Board complied with the district court's injunction by formally appointing Dr. Hyde to the Hospital's medical staff.

On the merits, the court of appeals reversed the decision of the district court. The court of appeals agreed with the district court that the exclusive contract created a tying arrangement,[18] but unlike the district court, the court of appeals held that the criteria for per se illegality were satisfied.

One difference between the decision of the district court and the decision of the court of appeals was the definition of the relevant geographic market. Whereas the district court had assumed without inquiry that the market for the provision of surgical facilities functioned in a

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(Footnote 16 continued)
part of the Board. (A., 77-78; see also the Memorandum in Support of Motion to Dismiss Appeal filed by the Hospital).

[17] The Hospital neither sought nor obtained a stay of the mandate of the court of appeals pending review by this Court.

[18] The court of appeals stated:

> The existence of a tying arrangement in this case has never been seriously disputed by appellees, since it is clear that users of the hospital's operating rooms (the tying product) are also compelled to purchase the hospital's chosen anesthesia service (the tied product). It is also clear that we are dealing with two distinct services which a buyer should be able to obtain separately.

686 F.2d at 289.

completely competitive manner, the court of appeals recognized that the market is affected substantially by factors other than comparisons of quality and price. 686 F.2d at 290. Citing the prevalence of third-party payment of bills and the inability of patients to evaluate and compare the quality of medical care offered, the court of appeals reasoned that patients and surgeons are more likely to choose a hospital (particularly a public hospital) close to their homes and offices. *Id.* The court held that the district court's failure to consider its own findings regarding the preference for nearby hospitals led it to define the relevant geographic market too broadly. *Id.* at 290-91.[19]

Under a narrower definition of the relevant geographic market, the court of appeals easily found that the Hospital had sufficient market power to restrain competition in the market for the tied product. Relying on this Court's decision in *Northern Pacific Railway Company v. United States*, 356 U.S. 1 (1958), the court of appeals held that the district court had erred in requiring a showing that the Hospital "dominated" the market for the tying product. 686 F.2d at 289. The court of appeals concluded that a market share of thirty percent provided "sufficient market power in the tying market to coerce purchase of the tied product." *Id.* at 291.

The court of appeals also took into account the several anticompetitive effects resulting from the use of exclusive contracts. In addition to directly preventing any real competition among anesthesiologists, the court noted that the use of exclusive contracts also discourages entry

[19] As further support for its conclusion that the relevant geographic market was limited to the East Bank of Jefferson Parish, the court of appeals noted the geographic limits placed on the District and the Board by state law. 686 F.2d at 291.

of new competitors into the market and reduces the incentive for improving the quality of anesthesia care provided by those already in the market. *Id.* at 291-92.

In response to the Hospital's claim that its tying arrangement was justified by business considerations, the court of appeals pointed out that the exclusive contract was not necessary to achieve any of the Hospital's asserted goals. Thus, the court held that the Hospital's asserted business justifications could not insulate the exclusive contract from per se illegality. *Id.* at 292.

SUMMARY OF ARGUMENT

1. The Hospital's exclusive contract with Roux & Associates was not a benign arrangement that merely permitted the Hospital to operate more efficiently without causing any detriment to patients. In fact, the contract was harmful to patients in several ways. First, it deprived both patients and surgeons of the freedom of choosing their own anesthesiologist, a freedom protected both by antitrust law and by traditional health care standards. Second, the exclusive contract is likely to be detrimental to the quality of patient care by encouraging a greater use of less qualified nurse anesthetists to the exclusion of M.D. anesthesiologists, and by eliminating the incentive for innovation and technical improvement by the contract group. Third, the economics of the exclusive contract indicate that it must have resulted in higher costs to patients. In sum, it is fair to say that exclusive contracts cause harm to patients.

2. Exclusive contracts restrain competition among anesthesiologists both directly and indirectly. Directly, the contract results in the denial to all but the chosen contract

group of what every anesthesiologist must have in order to compete—staff privileges. The fact that Dr. Hyde had staff privileges at another hospital did not cure the harm. Due to the Hospital's status as the only large public hospital in the market, the physicians to whom the Hospital grants staff privileges are given a competitive advantage over those to whom it does not. The Hospital offers greater professional opportunity than does any other hospital in the same market. Indirectly, exclusive contracts restrain competition by creating artificial barriers that discourage the entry into the market of new competitors. Similarly, exclusive contracts restrict the growth of existing anesthesiology groups.

3. The court of appeals correctly defined the relevant geographic market and correctly assessed the Hospital's market power. The district court's market definition was erroneous because it assumed incorrectly that the health care industry functions as a truly competitive market. When the recognized abberational economics of the health care industry are taken into account, it is clear that the Hospital's primary area of competition for the provision of surgical facilities is limited to the East Bank of Jefferson Parish. This conclusion is further supported by the statistical evidence presented at trial and the requirements of Louisiana law. Under a proper market definition, the Hospital unquestionably possessed sufficient power in the market for surgical facilities to restrain appreciably competition in the market for anesthesia services. It was not necessary for Dr. Hyde to show, as the district court had required, that the Hospital "dominated" the tying product market.

4. Both lower courts found that surgical facilities and anesthesia services are separate and distinct products that

could be the subject of a tying arrangement. These findings were supported by substantial evidence, including evidence that surgical facilities and anesthesia services are sold separately by many hospitals (including even the Hospital now that it has "opened" its department of anesthesia), that the two products are priced separately even by those sellers who do tie them together, and that state law requires that hospital services and professional medical services be separate. The several theories offered by the Hospital in support of its argument that surgical facilities and anesthesia services are only one product lack any legal or evidentiary support.

5. The only justification offered by the Hospital for the exclusive contract is that it results in certain "benefits" which permit the Hospital to operate more efficiently and, thereby, to compete better against other hospitals. Under prior decisions of the Court, this purported justification cannot serve to validate the tying arrangement proven by Dr. Hyde. Neither the Hospital nor the courts are in a position to decide that competition in one portion of the economy can be sacrificed in order to promote competition in another portion. This is a decision for Congress.

ARGUMENT

I. *EXCLUSIVE CONTRACTS CAUSE HARM TO PATIENTS.*

It is undisputed that the Hospital's exclusive contract with Roux & Associates deprived patients (either directly or through their surgeons) of the freedom to choose their own anesthesiologist. The evidence also demonstrated that an exclusive contract is likely to be detrimental to the quality of patient care rendered and probably

results in higher costs for patients. Therefore, it is fair to say that exclusive anesthesiology contracts are harmful to patients.

A. *The Contract Deprived Patients and Surgeons of the Freedom of Choice.*

The preservation of freedom of choice in the purchase of goods and services is a basic goal of the antitrust laws. A primary reason why tying arrangements are condemned is that they eliminate this freedom of choice. "One of the evils inherent in any tying arrangement is that it forces the buyer to give up his independent judgment as to whether, or where, to purchase the tied product." *Associated Press v. Taft-Ingalls Corporation*, 340 F.2d 753, 762 (6th Cir.), *cert. denied*, 382 U.S. 820 (1965); citing, *United States v. Loew's, Inc.*, 371 U.S. 38 (1962); *Northern Pacific Railway Company v. United States*, 356 U.S. 1 (1958). See also *United States v. Jerrold Electronics Corporation*, 187 F.Supp. 545, 554 (E.D. Pa. 1960), *aff'd mem.*, 365 U.S. 567 (1961).

Apart from antitrust policy, freedom of choice has always been considered a fundamental right of the patient in the American health care industry. Each of the physicians who testified at trial agreed that a patient should be free to select and be treated by the anesthesiologist of his or her choice. (R., Vol. I, 34-36, 64-65; R., Vol. II, 29, 157-58). A patient's interest in this freedom of choice is easy to understand. "The right to choose involves nothing less dramatic than the right to control what happens to one's body." Dolan and Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 Hous. L. Rev. 707, 721 (1981).

The Hospital does not dispute that it denied to the patients who used its operating rooms the freedom to choose an anesthesiologist. Instead, it argues that patients do not need this freedom because they would rarely exercise it. According to the Hospital, a patient depends entirely on his or her surgeon to select a hospital and an anesthesiologist. (Brief for the Petitioners, 41-42; R., 49-50).

However, the evidence at trial indicated that some patients do in fact want to have a choice in selecting an anesthesiologist. Dr. Charles Eckert, a member of Roux & Associates, testified that patients sometimes do request a specific anesthesiologist at the Hospital. (R., Vol. I, 87-88). Moreover, the frequency of specific requests by patients is greater with respect to Dr. Hyde's practice, which involves a substantial amount of obstetric work. Obstetric patients develop a closer relationship with their anesthesiologists because they remain conscious throughout the procedure and the anesthetic almost always is administered by an anesthesiologist rather than a nurse. (R., Vol. II, 61-64, 72-74). Therefore, the evidence is that some patients do exercise the freedom of choosing an anesthesiologist when it is permitted.

Even when a patient depends on his or her surgeon to choose an anesthesiologist, the exclusive contract still results in the denial of the freedom of choice. The surgeons who use the operating facilities at a hospital with an exclusive anesthesiology contract have no more freedom to choose an anesthesiologist than the patient. Despite what the patient might believe or the surgeon might desire, it is the hospital, not the surgeon, who chooses the anesthesiologist when one group is given an exclusive contract.

Although it is clear that a hospital takes the freedom

of choice away from patients and surgeons when it enters into an exclusive anesthesiology contract, "[i]t is unclear why a hospital should be allowed to substitute its judgment for the patient's judgment." Dolan and Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 Hous. L. Rev. 707, 721 (1981). Patients and surgeons may choose an anesthesiologist for personal or commercial reasons that are unrelated to any of the hospital's interests. *Id.* The hospital's judgment, therefore, may not satisfy the needs of the patient.

Nor is the denial of patients' freedom of choice justified by the Hospital's argument that patients (and presumably surgeons) can go elsewhere if they are unhappy with the Hospital's choice of anesthesiologists. (Brief for the Petitioners, 30). Normally, an anesthesiologist is retained only after a patient already has been admitted to, or has been scheduled for surgery at, a particular hospital. As both lower courts recognized, a particular hospital is selected by the patient or surgeon more on the basis of location than any other factor. As long as the anesthesiologist who is available at a particular hospital is competent, a patient or surgeon is unlikely to change hospitals in order to be able to retain another anesthesiologist.

The choice of a surgeon or a hospital is made separately from and in advance of the choice of an anesthesiologist. Thus, even patients and surgeons who otherwise would exercise the freedom to choose an anesthesiologist are likely to allow a chosen hospital to dictate that choice. The fact that patients and surgeons *can* go to other hospitals is not the point. The crucial question is whether patients and surgeons actually *do* change hospitals in order to have a broader choice among anesthesiologists. The realities of the market place indicate that they do not.

The freedom of choice is an important goal, not only for antitrust law but also for the American health care system. Any arrangement that eliminates the freedom of choice should bear a heavy burden of justification.

B. *The Contract Is Detrimental to the Quality of Patient Care.*

The court of appeals set aside as clearly erroneous the district court's finding "that strictly quality considerations led the hospital to enter into an exclusive contract." 686 F.2d at 291 n. 7. The court of appeals was correct. The evidence demonstrated that exclusive contracts actually are detrimental to the quality of patient care for two reasons. First, they result in the replacement of M.D. anesthesiologists with less qualified nurse anesthetists. Second, they eliminate any incentive on the part of the contract group for medical improvement or innovation.

Nurse anesthetists, by themselves, are not detrimental to patient care.[20] To the contrary, in areas where there is a shortage of anesthesiologists they are necessary to the provision of anesthesia services. (R., Vol. I, 12, 82-83; R., Vol. II, 44-45). However, nurse anesthetists are not physicians and they are not licensed to practice medicine. They are authorized to administer anesthetics only under the supervision of a licensed physician. Any arrangements that encourages a greater use of nurse anesthetists to the exclusion of anesthesiologists must be detrimental to

[20] The court of appeals disclaimed any intention "to denigrate the competence of nurse anesthetists." 686 F.2d 291 n. 8. We likewise disclaim any similar intention; nor do we contend that it is improper for nurse anesthetists to administer anesthetics under the medical direction of an anesthesiologist or other qualified physician.

patient care in the long run.[21]

When the exclusive contract between the Hospital and Roux & Associates was in effect, both parties had an economic incentive to utilize as many nurse anesthetists and as few M.D. anesthesiologists as possible. A patient paid the same price regardless whether the anesthetic was administered by a member of Roux & Associates or by a nurse anesthetist employed by the Hospital. Moreover, the patient would pay the same price regardless whether a member of Roux & Associates appeared in the operating room or was even present in the Hospital.[22] Inasmuch as the cost of employing a nurse anesthetist is only a fraction of the cost of employing an M.D. anesthesiologist, a simple profit motive would dictate as many nurse anesthetists and as few M.D. anesthesiologists as possible be employed. Under the exclusive contract, both the Hospital and Roux & Associates would benefit from this form of profit maximization because they shared the proceeds generated by the department of anesthesia. Therefore, neither of them could be expected to protect the interest of patients, who might prefer to receive the professional coverage they were paying for.

Now that the Hospital has "opened" its department of anesthesia and has ended its partnership with Roux & Associates, it no longer faces a financial conflict of interest

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[21] If this conclusion is incorrect, then there would seem to be no reason to train anesthesiologists. Nurse anesthetists could do just as good a job. However, the undisputed evidence was that nurse anesthetists remain necessary only because there still are not enough anesthesiologists. (R., Vol. II, 44-46).

[22] This practice was criticized by the court of appeals as lacking candor in that the patient normally does not realize "that he will be billed for the services of an anesthesiologist who may have had very little contact with his case." 686 F.2d at 291 (footnote omitted). The district court described the practice as "a ripoff." (R., Vol. II, 38).

concerning the use of nurse anesthetists. The anesthesiologists (including Roux & Associates) now practicing at the Hospital employ nurse anesthetists directly and bill their patients directly. The Hospital no longer employs nurse anesthetists or splits professional fees with Roux & Associates.[23] Thus, the Hospital no longer profits from the practice of charging professional fees for work done by nurse anesthetists. The Hospital now is in a position to concern itself with the quality of anesthesia services being rendered, rather than the profits to be realized from them.

Exclusive anesthesiology contracts also are detrimental to the quality of patient care for another, perhaps more subtle, reason: they tend to reduce the incentive for medical improvement and innovation. Product improvement and innovation are basic goals of competition. The monopolist has little economic incentive to improve his product because it is unlikely that by doing so he will increase his sales. In a competitive market, on the other hand, product improvement and innovation often are necessities for survival. In this respect the market for anesthesia services is no different. Where there is no intrahospital competition among anesthesiologists, there is little incentive for the monopolist group to improve the quality of its care or to try innovative procedures. Where there is competition, however, no group can afford to refuse to use improved and innovative procedures for fear of losing business.[24]

In *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), the Court stressed the importance of product improvement and innovation derived from competi-

[23] The Hospital does still bill patients for the use of equipment, drugs and supplies.

[24] See testimony of Dr. John Adriani quoted at pages 11 and 12, *supra*.

tion. In describing the adverse effects of the illegal maximum price-fixing agreement the Court said:

> In this case the rule is violated by a price restraint that tends to provide the same economic rewards to all practitioners regardless of their skill, their experience, their training or their willingness to employ innovative and difficult procedures in individual cases. Such a restraint also may discourage entry into the market and may deter experimentation and new developments by individual entrepreneurs.

457 U.S. at 348.

Exclusive contracts in the field of anesthesiology have the same effect. They discourage improvement and innovation by shielding the contract group from competition. Where competition is permitted, innovation and improvement become necessary for survival and the patients benefit. Exclusive contracts, by precluding this beneficial competition, are detrimental to the quality of patient care.

C. *The Contract Must Have Resulted in Higher Costs to Patients.*

The evidence at trial did not establish directly whether the Hospital's exclusive contract with Roux & Associates resulted in higher, lower or unchanged costs to patients.[25] This inconclusiveness should not be surprising in a tying case because one purpose of tying is to disguise the prices being charged for tied products. P. Areeda,

[25] The court of appeals' statement that "it is true that the tying of anesthesia services to operating rooms in the instant case did not lead to a higher charge for anesthesia services," 686 F.2d at 291, merely reflected the inconclusive nature of the direct evidence; it did not constitute a holding of the court.

Antitrust Analysis 572 (2d ed. 1974).[26] However, a consideration of the economics of the exclusive contract indicates that it must have resulted in higher costs to patients.

First, "[c]onventional economic wisdom predicts that as the supply of practitioners with privileges in a relevant specialty area increases, the price of services will decrease if demand remains constant." Dolan and Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 Hous. L. Rev. 707, 716 (1981); see also, *Id.* at 732. Even in the imperfect health care market, the rules of supply and demand must have some effect. Exclusive contracts unquestionably limit the supply of anesthesiologists available to serve patients and must hereby tend to increase the price of anesthesia services to some extent.

Second, the fact that the exclusive contract required Roux & Associates to share its fees (and profits) with the Hospital indicates that the fees were higher than they otherwise would have been. The fifty percent share of anesthesia proceeds retained by the Hospital under the exclusive contract was a negotiated figure that was unrelated to the Hospital's actual costs (R., 85-86). Because its share of the proceeds significantly exceeded its actual costs, the Hospital derived a substantial profit under the contract. (A., 51). In the absence of the exclusive contract, this profit realized by the Hospital would have been retained by Roux & Associates.

Roux & Associates is a profit-motivated entity and it is reasonable to assume that it would not have agreed to

[26] Thus, even though the Hospital imposed separate charges for use of its surgical facilities and the provision of anesthesia services, the charges may not have reflected a true allocation of the Hospital's costs.

work under a contract which had the effect of lowering the income it otherwise would have realized. However, under its contract, Roux & Associates had to share at least some of its profit with the Hospital.[27] The only way in which Roux & Associates could have shared its profit with the Hospital and yet still have realized the same level of income that it otherwise would have earned was to increase the level of profits by raising the prices charged to patients. Thus, although there was no evidence directly showing that Roux & Associates raised its prices, common sense indicates that it must have done so. At the very least, the fee sharing arrangement in the exclusive contract created an inducement for Roux & Associates to raise its prices.

The exclusive contract gave the Hospital the power to exercise some control over the prices charged by Roux & Associates. (A., 26). However, for unexplained reasons, the Hospital choose not to exercise this power. Instead, the Hospital allowed Roux & Associates to set the fees. (R., 84). Thus, the exclusive contract provided an inducement for Roux & Associates to raise its prices without also providing any effective countervailing control.

Although neither lower court made a finding concerning the effect of the exclusive contract on prices, a common sense analysis indicates that the contract must have resulted in higher prices. At the very least, the contract had the effect of maintaining prices at a level higher than they otherwise would have been.

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[27] To the extent that the Hospital's share of the fees exceeded its costs, it represented profit which would have been retained by Roux & Associates in the absence of a contract.

II. *EXCLUSIVE CONTRACTS SUBSTANTIALLY ELIMINATE COMPETITION AMONG ANESTHESIOLOGISTS.*

Exclusive contracts substantially eliminate competition among anesthesiologists both directly and indirectly. Competition is restrained directly by the denial to all but the contract group of something that each anesthesiologist must have in order to compete for business in any hospital: staff privileges. Indirectly, exclusive contracts restrain competition by discouraging new anesthesiologists from entering the market and restricting the growth of existing anesthesia groups.

Normally, an anesthesiologist is selected by a surgeon, rather than a patient, on the basis of an existing working relationship. (R., Vol. II, 26-27). In order for a surgeon and an anesthesiologist to develop a working relationship, they must have the opportunity to work together on a regular basis. (R., Vol. II, 27). By denying Dr. Hyde admission to the medical staff, the Hospital also denied him the opportunity to develop a working relationship with the surgeons who utilize the Hospital's surgical facilities. If the surgeons who work at the Hospital are compelled to use only the anesthesiologists employed by Roux & Associates on a regular basis, then those are the only anesthesiologists with whom they will become familiar and, therefore, the only anesthesiologists that they will use.[28]

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[28] Moreover, the nature of Dr. Hyde's practice makes it much more likely that patients as well as surgeons will request his services. See discussion at page 22, *supra*. Thus, Dr. Hyde's exclusion from the Hospital's medical staff prevented his selection by patients as well as by surgeons.

The fact that Dr. Hyde had staff privileges at another hospital did not necessarily cure the harm. First, the denial of medical staff privileges "is a competitive disadvantage, if for no other reason than it connotes a second-class practitioner." Dolan and Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 Hous. L. Rev. 707, 714 (1981). This is particularly true at a community hospital perceived by patients to be "public" in the sense of being open to all qualified physicians. Second, the evidence showed that staff membership at the Hospital, because it is a large, public facility, offers greater professional opportunities to anesthesiologists than does staff membership at a smaller facility. For example, at Lakeside Hospital, where Dr. Hyde primarily practiced, approximately fifty percent of the cases are obstetric (R., Vol. II, 62). An anesthesiologist at Lakeside does not have the opportunity to do the more complicated cases and to use the more sophisticated equipment available at a large facility like the Hospital. (R., Vol. I, 90-91).

In *Associated Press v. United States*, 326 U.S. 1 (1945), the Court held that a wire service's restrictive bylaws violated the Sherman Act by restraining competition among newspapers. In response to the argument that the wire service did not have to sell news to all newspapers because there were other news agencies which provided similar services, the Court stated:

> But the fact that an agreement to restrain trade does not inhibit competition in all of the objects of that trade cannot save it from the condemnation of the Sherman Act. It is apparent that the exclusive right to publish news in a given field, furnished by AP and all of its members gives many newspapers a competitive advantage over their rivals. Conversely, a newspaper without AP

> service is more than likely to be at a competitive disadvantage.

326 U.S. at 17-18 (footnotes omitted).

Just as a newspaper can survive without the Associated Press, so can an anesthesiologist practicing in Jefferson Parish, Louisiana survive without staff membership at the Hospital. After all, there are other hospitals at which to practice.[29] However, that is not the test according to *Associated Press v. United States.* By virtue of the Hospital's size, public nature and reputation as a quality facility, the physicians to whom it grants staff privileges are given a competitive advantage over those to whom it does not. The result is particularly objectionable where, as here, the competitive advantage is based not on the relative skill and competence of the competitors, but rather on a contract.

In addition to the direct anticompetitive effects, exclusive contracts also restrain competition among anesthesiologists indirectly by restricting practice opportunities and thereby discouraging the entry of additional anesthesiologists into the market. Although there is a shortage of anesthesiologists in the area, locally trained anesthesiologists actually are forced to go elsewhere to practice because of the lack of local openings. (R., Vol. II, 30-31). For the same reason, anesthesiologists from other areas are discouraged from entering the market (R., Vol. II, 92-95). As a practical matter, an anesthesiologist must find employment with an existing group if he or she is to work at all.

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[29] In fact, of all the hospitals in Jefferson *and* Orleans Parishes, only three had "open" anesthesiology departments at the time of trial. (R., Vol. II, 47-49). Therefore, those three hospitals would have to support all of the anesthesiologists who were not fortunate enough to have exclusive contracts at the others.

However, even the existing groups are restricted in the employment of new members because they are prevented from expanding their practices into hospitals that maintain exclusive contracts with other groups.[30]

In essence, the Hospital's exclusive contract with Roux & Associates created a monopoly that protected both Roux & Associates and the Hospital from competition.[31] Where, as here, most of the hospitals in the area utilize exclusive contracts, the result is a shared monopoly, with each hospital and contract anesthesiology group being allocated a portion of the market. See Dolan and Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 Hous. L. Rev. 707, 760 (1981); Kissam, Webber, Bigus and Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 Calif. L. Rev. 595, 664 (1982). This division of the market does not merely restrict, but substantially eliminates competition among anesthesiologists. See *United States v. Topco Associates, Inc.*, 405 U.S. 596 (1972).

The Hospital argues that the foreclosure of competition on a local level is unimportant because anesthesiologists "compete" for exclusive contracts on a national basis. (Brief for the Petitioners, 36-39). This argument lacks merit for several reasons. First, it conveniently ignores the fact that anesthesiologists are mobile primarily because local anticompetitive conditions force them to be. Anesthesiologists often are unable to find positions in areas in which

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[30] For example, Dr. Hyde described at trial how the inability of his group to practice at the Hospital made it more difficult to recruit new group members. (R., Vol. II, 79-80).

[31] The two members of the Hospital Board who testified at trial agreed that the exclusive contract created a monopoly for Roux & Associates. (R. Vol. II, 158-59, 195).

the use of exclusive contracts are prevalent. Therefore, they must be mobile in order to work. It is easy to minimize the significance of a competitive restraint in a local market simply by increasing the size of the market until the restraint becomes "immaterial in this larger perspective." (Brief for the Petitioners, 37). This academic exercise, however, does not reduce the impact of the restraint on local competition.

Second, the Hospital's argument is based on the false premise that anesthesiologists sell their services to hospitals rather than patients. Hospitals neither receive anesthesia nor pay for it. Patients do. It is true that, in the absence of exclusive contracts, anesthesiologists normally are selected by surgeons. It also is true that hospitals, by utilizing exclusive contracts, take the selection of an anesthesiologist out of the hands of the surgeon. However, the patient is always the purchaser and the consumer of the anesthesia. Roux & Associates no longer has any contractual relationship with the Hospital and it bills patients directly for anesthesia services. Surely the Hospital would not claim that it now purchases anesthesia services from Roux & Associates.

A third flaw in the Hospital's argument is that it assumes, incorrectly, that anesthesiologists actively compete for exclusive contracts. The evidence is to the contrary. The Hospital selected Dr. Roux before it opened its doors in 1971 and it has not required Roux & Associates to compete with any other group since then. The only competition has been between Roux & Associates and the Board over whether Roux & Associates would be allowed to practice at the Hospital without a contract.[32] When the Hospital attempted

[32] The Hospital's assertion that the 1976 contract was preceded by "a second round of bids in 1976" (Brief for the Petitioners, 39) has no evidentiary basis.

to negotiate with Dr. Roux in 1975 to renew the 1971 contract, Dr. Roux initially refused to negotiate and took the position that his group would employ nurse anesthetists and bill patients directly. (R., Vol. II, 134, 158-59). Dr. Roux finally signed the 1976 contract only after the Hospital threatened to contract with another group, which would mean that Roux & Associates could no longer practice at the Hospital. (R., Vol. II, 160-63). Thus, as the court of appeals observed, "the hospital, in fact, has not permitted this competition [for the exlusive contract] since the original contract was signed over ten years ago." 686 F.2d at 291-92 n. 9.

Moreover, even if there were limited competition among anesthesiologists to obtain exclusive contracts, overall competition still would be severely restrained. If each of the thirteen judges of the United States District Court for the Eastern District of Louisiana chose two law firms and required each litigant to employ one of the two firms, competition among lawyers obviously would be restrained. Instead of having the freedom to choose among the thousands of lawyers licensed in the district, a litigant would be required to choose from among only those lawyers employed by the twenty-six law firms chosen by the district judges. Arguably, the judges are in a better position than an individual litigant to evaluate and bargain with the law firms chosen and the system undoubtedly would simplify court administration. Furthermore, assuming that it were permitted, law firms would be likely to compete with one another to be selected by the judges. However, it could not be said that this arrangement would not severely restrain competition among lawyers. Among the thousands of lawyers who otherwise would be available to represent litigants, the entire market would be allocated to those employed by the twenty-six chosen law firms.

The competitive impact of the use of exclusive contracts in the field of anesthesiology is no different. Exclusive contracts restrain competition among anesthesiologists by limiting artificially the choices available to patients and surgeons. Therefore, the exclusive contract is illegal.

III. *THE COURT OF APPEALS' DETERMINATIONS REGARDING THE RELEVANT GEOGRAPHIC MARKET AND THE HOSPITAL'S MARKET POWER WERE CORRECT.*

A. *The East Bank of Jefferson Parish Is the Relevant Geographic Market.*

The district court defined the relevant geographic market to include at least the East Bank of both Jefferson and Orleans Parishes. 513 F.Supp. at 540. The court of appeals held that the district court's market definition was erroneous because it assumed incorrectly that the health care industry functioned as "a truly competitive market." 686 F.2d at 290. The court of appeals recognized that, given the market imperfections inherent in the health care industry, the geographic market in which the Hospital primarily competes actually is limited to the East Bank of Jefferson Parish.

The abberational economics of the health care industry has been widely recognized. See, *e.g.*, M. Thompson, *Antitrust and the Health Care Provider* (1979) 33-36; Dolan and Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 Hous. L. Rev. 707, 738-39 (1981); Shapiro, *Cost Containment in the Health Care Field and the Antitrust Laws*, 7 Am. J. of Law and Medicine 425, 428-29 (1982); Note, *Antitrust and Nonprofit Entities*, 94

Harv. L. Rev. 802, 803-05 (1981). In general, the commentators agree that the health care industry is a closed market characterized by heavy government regulation, a lack of information on the part of patients regarding quality and prevalent third party payment of medical fees. Patients realistically cannot compare the quality of hospital services offered at different hospitals and, due to third party payment of fees, they have no incentive to compare cost. Therefore, patients tend to favor public, nonprofit facilities[33] close to their homes. Similarly, surgeons are likely to favor hospitals close to their offices.

The district court in fact recognized the preference of patients for hospitals near their homes. It stated:

> It is likely that any individual will choose to go to the hospital closest to his home if it is possible to do so for the convenience of the family. Persons living nearer to hospitals in other areas will choose to go to those hospitals if possible.

513 F.Supp. at 543. In other words, the district court found that, all other things being equal, a resident of the East Bank of Jefferson Parish probably will prefer to be admitted to a hospital in that area over all other hospitals in other surrounding areas. However, the district court inexplicably failed to take this finding into account in defining the relevant geographic market. As the court of appeals was unable to reconcile the district court's findings, it held that the court's market definition was erroneous. 686 F.2d at 290-91.

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[33] Public, nonprofit entities are likely to be favored because they have no apparent profit motive to cut quality. Note, *Antitrust and Nonprofit Entities*, 94 Harv. L. Rev. 802, 803-04 (1981).

The conclusion that the Hospital's area of effective competition is limited to the East Bank of Jefferson Parish also was supported by the statistical evidence presented at trial. That evidence showed that over seventy percent of all persons admitted to the Hospital during the study period resided on the East Bank of Jefferson Parish. (A., 50). Furthermore, approximately thirty percent of all hospital admissions of East Bank Jefferson Parish residents were to the Hospital. These figures indicate that the Hospital competes primarily only on the East Bank of Jefferson Parish.

The court of appeals found further support for its geographic market definition in the statutory limitation placed on the District and the Board by state law. The statutory purpose of the District is to own and operate hospitals within the District and to provide hospital and other health services to the residents of the District. La. R.S. 46:1052. As the geographic boundaries of the District encompass only that part of Jefferson Parish located on the East Bank of the Mississippi River (Pl. Ex. 1; R., 7, 94), that is the area in which the District is directed by the statute to perform its purpose. Similarly, the Board is directed by La. R.S. 46:1055 "[t]o represent the public interest in providing hospital and medical care *in the district.*" (emphasis supplied). Thus, by law, the Hospital's primary purpose is to serve the residents of the East Bank of Jefferson Parish. Although the Hospital may, by necessity or by choice, also accept residents of other areas, its primary market area is limited by law to the East Bank of Jefferson Parish.

Taken as a whole, the evidence showed that the Hospital's primary area of competition is the East Bank of Jefferson Parish. Accordingly, the court of appeals was correct in holding that the district court's broader market definition was erroneous.

B. *The Hospital Has Sufficient Market Power to Establish a Per Se Violation.*

The evidence demonstrated that the Hospital captures almost thirty percent of all patients residing in the relevant geographic market. Based upon this evidence, the court of appeals held that the Hospital's power in the market for the tying product was sufficient to satisfy the test for per se illegality. The court of appeals unquestionably was correct.

The decisions of this Court have never required a showing of monopoly, or even dominant, market power in the tying product in order to establish a per se illegal tying arrangement. In *International Salt Company v. United States*, 332 U.S. 392 (1947), the Court affirmed a summary judgment holding illegal leases of salt dispensing machines that required the lessee to use the machine only with salt purchased from the lessor. The only evidence of the lessor's market power was that its annual sales of salt amounted to almost $500,000. In affirming, the Court stated that "it is unreasonable, *per se*, to foreclose competitors from any substantial market" and that the lessor's sales volume "cannot be said to be insignificant or insubstantial...." *Id.* at 396.

In *Fortner Enterprises, Inc. v. United States Steel Corporation*, 394 U.S. 495, 503-04 (1969) ("*Fortner I*"), the Court made the following observation concerning the showing of tying product power required:

> [D]ecisions rejecting the need for proof of truly dominant power over the tying product have all been based on a recognition that because tying arrangements generally serve no legitimate

> business purpose that cannot be achieved in some less restrictive way, the presence of any appreciable restraint on competition provides a sufficient reason for invalidating the tie. Such appreciable restraint exists whenever the seller can exert some power over some of the buyers in the market, even if his power is not complete over them...[D]espite the freedom of some or many buyers from the seller's power, other buyers—whether few or many, whether scattered throughout the market or part of some group within the market [could] be forced to accept [a] higher price because of their strong preferences for the product, and the seller could therefore choose instead to force them to accept a tying arrangement that would prevent free competition for their patronage in the market for the tied product.

The Court restated its position concerning the degree of market power required in *United States Steel Corporation v. Fortner Enterprises, Inc.*, 429 U.S. 610 (1977) ("*Fortner II*"). The Court said:

> As the Court plainly stated in its prior opinion in this case, *these decisions do not require that the defendant have a monopoly or even a dominant position throughout the market for a tying product.* They do, however, focus attention on the question whether the seller has the power, within the market for the tying product, to raise prices or to require purchasers to accept burdensome terms that could not be exacted in a completely competitive market. In short, the question is whether the seller has some advantage not shared by his competitors in the market for the tying product.

Id. at 620-21 (emphasis supplied; citation and footnote omitted).

The Hospital has the competitive "advantage" described in *Fortner II* by virtue of its unique position as the only public hospital on the East Bank of Jefferson Parish. As discussed in Part A, above, the health care industry is characterized by market imperfections that favor public, nonprofit hospitals located near patients and their physicians. Given the inability to compare quality and the lack of incentive to compare cost, patients and surgeons are more likely to choose a public facility which has no apparent profit motive to reduce quality.

The Hospital's ability to attract almost thirty percent of all hospital patients residing on the East Bank of Jefferson Parish is a good indication of the market power that it possesses. The Hospital's role as the only public institution in the market creates a "strong preference" (*Fortner I*) for its surgical facilities and gives it the power "to raise prices or to require purchasers to accept burdensome terms that could not be exacted in a completely competitive market" (*Fortner II*). One burdensome term that patients were required to accept was the Hospital's refusal to allow them to select the anesthesiologist of their choice. In addition, the ability of the Hospital to utilize a tying arrangment gave it the power to raise prices for its surgical facilities by disguising the additional costs as anesthesia fees.

It was not necessary for Dr. Hyde to show, as the district court required, that the Hospital "dominated" the tying product market. The Hospital possesses sufficient power in the market for surgical facilities to restrain competition in the market for anesthesia services. Accordingly, the market power requirement for per se illegality was satisfied.

IV. *SURGICAL FACILITIES AND ANESTHESIA SERVICES ARE SEPARATE AND DISTINCT PRODUCTS.*

Both the district court and the court of appeals found that surgical facilities and anesthesia services are separate and distinct products. These findings are well supported by fact and by law.

First, it is undisputed that surgical facilities and anesthesia services are sold separately by many hospitals.[34] Indeed, now that it has "opened" its department of anesthesia, even the Hospital sells these products separately. The existence of other sellers who do not "package" their products is one indication of product separability. *United States v. Jerrold Electronics Corporation*, 187 F.Supp. 545, 559 (E.D. Pa. 1960), *aff'd mem.*, 365 U.S. 567 (1961).

Second, surgical facilities and anesthesia services are separately priced even by those sellers who do tie them together. Although separate pricing by itself would not establish the existence of two products, it is another factor which tends to show that two products exist. *Id.*

Third, hospitals and physicians are subject to

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[34] It is important to recognize the difference between clinics, such as the Mayo Clinic or the Cleveland Clinic, and acute care general hospitals. Clinics combine in a single business medical services and all ancillary facilities necessary to provide those services from initial consultation to final surgery and convalescence. In the case of a clinic, the patient looks to the institution for medical care and all attendant ancillary services and the institution can be said to compete with other similar institutions. The Hospital is not a clinic. In most instances, patients who are admitted to the hospital go initially to an individual physician or group of physicians.

separate and independent licensing systems which *require* that hospital services and medical services be separate. Under Louisiana law, a hospital legally cannot engage in the practice of medicine. Only the physicians who practice within the hospital are licensed to practice medicine.[35] Therefore, it is the members of Roux & Associates, not the Hospital, who rendered anesthesia services to patients; and the rendering of professional anesthesia services by licensed physicians cannot be characterized as merely a part of "hospital care."

In his complaint, Dr. Hyde alleged that the exclusive contract violated Louisiana law because it called for "fee splitting" between Roux & Associates and the Hospital and the exercise of professional medical discretion by the Hospital. (A., 6-7). In other words, Dr. Hyde alleged what the petitioners argue now: that the Hospital actually was practicing medicine by providing professional anesthesia services to patients. The district court, however, disagreed. It stated:

> The Court finds that the hospital did not improperly engage in the diagnosis and treatment of patients. *The evidence shows that the anesthesia services are provided by the anesthesiologist who prescribes the drugs used and performs all procedures requiring expertise.* The CRNA's work under the supervision of the anesthesiologists and their function is to monitor the patients while they are anesthetized.

[35] The petitioners' attempt to analogize the Hospital to a law firm (Brief for the Petitioners, 40 n. 24) misses the point. The individual lawyers in a law firm either own or are employed by the firm. Thus, the firm can act only through them. The Hospital neither was owned by nor did it employ Roux & Associates. Roux & Associates is a professional corporation which itself employs the individual anesthesiologists. Therefore, a better analogy could be drawn between a law firm and a professional corporation of anesthesiologists.

513 F.Supp. at 540 (emphasis supplied).

Thus, the district court found that the provision of anesthesia services is not merely a part of a total "package" of hospital services. Rather, it is a professional service rendered by licensed anesthesiologists who are legally responsible for the anesthesia care received by the patients. As the district court observed, the Hospital furnishes only materials and nonprofessional services "in connection with" the work of the anesthesiologists.

In the face of the contrary findings of both lower courts, the Hospital argues in this Court that surgical facilities and anesthesia services really are only one product.[36] In support of this argument the Hospital offers several different theories.

First, it is asserted that surgical facilities and anesthesia services are one product "because it is often more economical to supply them together than to supply them separately." (Brief for the Petitioners, 39). Economical for whom? Certainly not the patient. The economics of the challenged exclusive contract indicate that, in all probability, it resulted in higher prices for patients. At the very least, the contract created an inducement for Roux & Associates to raise its prices in order to recoup the profits that it distributed to the Hospital. Furthermore, the Hospital declined to exercise any control over the prices set by Roux & Associates. Any assertion that the Hospital's patients received some economic

[36] We do not contend, as the petitioners suggest (Brief for the Petitioners, 39 n. 23), that this issue was not preserved in the court of appeals. We merely point out that this issue was not raised by the Hospital in the lower courts.

benefit simply has no evidentiary basis.[37]

The second theory offered by the Hospital in support of its one-product argument is that two products cannot be the subject of a tie unless each is "independently useful" and cannot be "conveniently used as a unit." (Brief for the Petitioners, 40). This cannot be the test. Computers and punch cards had no independent usefulness and were conveniently used together; yet they were held to be the subjects of an illegal tying arrangement in *International Business Machines Corporation v. United States*, 298 U.S. 131 (1936). Salt and salt dispensers could be "conveniently used as a unit," yet they were considered to be separate products for tying purposes in *International Salt Company v. United States*, 332 U.S. 392 (1947). Similarly, in *United States v. Jerrold Electronics Corporation*, 187 F.Supp. 545 (E.D. Pa. 1960), *aff'd mem.*, 365 U.S. 567 (1961), the components of a television antenna system were held to be separate products. Independent usefulness may be one factor to consider in determining product separability. It is not, as the Hospital suggests, the sole criterion.

Finally, the Hospital asserts that "[t]he only useful approach is to ask whether the particular aggregation threatens competition on the merits." (Brief for the Petitioners, 42). This is not much different than the require-

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[37] If the Hospital means to say that the exclusive contract is "economical" in the sense that it was needed in 1971 in order to attract an anesthesiologist to the Hospital (see testimony of Dr. John C. Rourke and Nickolas Gagliano quoted at pages 5-6, *supra*), that situation is no longer the case. (R., Vol. II, 196-97). Where a defendant seeks to justify a tying arrangement on grounds of economic necessity, he has "the burden not only of establishing the initial existence of the facts necessary to support [his] claim but also their continuing existence in view of the fact that it is not disputed that the conditions did change." *United States v. Jerrold Electronics Corporation*, 187 F.Supp. 545, 560 (E.D. Pa. 1960), *aff'd mem.*, 365 U.S. 567 (1961).

ment of *Northern Pacific Railway Company v. United States*, 356 U.S. 1, 6 (1958), that the defendant be shown to have "sufficient economic power with respect to the tying product to appreciably restrain free competition in the market for the tied product." As discussed in Section II of this Argument, the exclusive contract unquestionably does restrain competition in the market for anesthesia services. It directly denies to all but the contract group what any anesthesiologist must have in order to compete—staff privileges. Moreover, it indirectly impairs competition by creating serious entry barriers for new anesthesiologists. If the effect on competition is the test, then surgical facilities and anesthesia services clearly are separate and distinct products.

The findings of the lower courts that surgical facilities and anesthesia services are separate products are supported by the evidence and the law. The arguments of the Hospital against those findings are unsupported and should be rejected by the Court.

V. *THE PURPORTED JUSTIFICATIONS OFFERED BY THE HOSPITAL FOR THE EXCLUSIVE CONTRACT CANNOT VALIDATE THE TYING ARRANGEMENT THAT THE CONTRACT CREATED.*

Once a per se rule is found applicable, economic or competitive justifications for a restraint of trade become irrelevant. Therefore, the purported justifications offered by the Hospital for the exclusive contract legally cannot validate the tying arrangement created by the contract.

In the lower courts, the Hospital identified several purported benefits that it contended were derived from the

"closed" staff system utilized in the department of anesthesiology. These purported benefits included the assurance of twenty-four hour a day anesthesia coverage, easier monitoring of specialized equipment and supervision of nurse anesthetists, greater flexibility in scheduling the use of operating rooms, and allowing anesthesiologists and nurse anesthetists to form a closer working relationship. See 686 F.2d at 288; 513 F.Supp. at 540. The Hospital contends that these benefits allow it to operate more efficiently and thereby help it compete against other hospitals.

The court of appeals found that these "benefits" either were not shown by the record to exist or obviously could be achieved by less restrictive means. 686 F.2d at 292. More importantly, the court of appeals rejected in principle the Hospital's argument that the tying arrangement created by the exclusive contract could be justified by these asserted procompetitive benefits. *Id.* at 294. The court of appeals' ruling on this issue was consistent with the decisions of this Court, and therefore, it should be upheld.

In *United States v. Topco Associates, Inc.*, 405 U.S. 596 (1972), the Court held that an exclusive territorial licensing system for private label supermarket brands was illegal per se because it eliminated intrabrand competition at the retail level. In defense of the system, the cooperative association which owned the private label brands argued that the restriction of intrabrand competition actually was procompetitive in that it helped the association's "members to compete successfully with larger regional and national chains." *Id.* at 606. The Court flatly rejected this argument, stating:

> in particular, are the Magna Carta of free enterprise. They are as important to the preservation of economic freedom and our free-enterprise system as the Bill of Rights is to the protection of our fundamental personal freedoms. And the freedom guaranteed each and every business, no matter how small, is the freedom to compete—to assert with vigor, imagination, devotion and ingenuity whatever economic muscle it can muster. *Implicit in such freedom is the notion that it cannot be foreclosed with respect to one sector of the economy because certain private citizens or groups believe that such foreclosure might promote greater competition in a more important sector of the economy.*

405 U.S. at 610 (emphasis supplied).[38] The Court concluded that "[i]f a decision is to be made to sacrifice competition in one portion of the economy for greater competition in another portion this too is a decision that must be made by Congress and not by private forces or by the courts." *Id.* at 611. See also *National Society of Professional Engineers v. United States*, 435 U.S. 679 (1978).

More recently, in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), the Court again flatly rejected the argument that procompetitive justifications could save what otherwise was a per se illegal restraint. The court said:

> The argument indicates a misunderstanding of the *per se* concept. The anticompetitive potential inherent in all price fixing agreements justifies

[38] The Court also pointed out that "[o]ur inability to weigh, in any meaningful sense, destruction of competition in one sector of the economy against promotion of competition in another sector is one important reason we have formulated *per se* rules." 405 U.S. at 609-10.

> their facial invalidation even if procompetitive justifications are offered for some. Those claims of enhanced competition are so unlikely to prove significant in any particular case that we adhere to the rule of law that is justified in its general application.

457 U.S. at 351 (footnote omitted).

Maricopa and *Topco* are controlling here. Dr. Hyde proved the existence of a per se illegal tying arrangement. The Hospital's only real defense is that the exclusive contract which created the tying arrangement is justified because it makes the Hospital more efficient and thereby helps it compete against other hospitals. This argument was foreclosed by *Topco* and *Maricopa*.

CONCLUSION

The Hospital's exclusive contract with Roux & Associates created a per se illegal tying arrangement. The decision of the court of appeals was correct and it should be affirmed.

Respectfully submitted,

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In the Supreme Court of the United States.

OCTOBER TERM, 1982.

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2
AND
EAST JEFFERSON HOSPITAL BOARD,
PETITIONERS,

v.

EDWIN G. HYDE,
RESPONDENT.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT.

Brief of Amicus Curiae, the American Association of Nurse Anesthetists.

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Brief of Amicus Curiae, the American Association of Nurse Anesthetists.

Pursuant to Rule 36 of the rules of this Court, and with the consent of all parties,[1] the American Association of Nurse Anesthetists respectfully files this brief as *amicus curiae*.

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[1] Letters of consent have been filed with the clerk.

Interest of the American Association of Nurse Anesthetists.

The American Association of Nurse Anesthetists ("AANA") is a national professional organization, organized in 1931, which sets standards for the practice of nurse anesthetists and consists of approximately 23,000 certified registered nurse anesthetists ("CRNAs"). The AANA publishes standards which serve as general guides for the rendering of anesthesia care and interpretations explaining these standards.

Nurse anesthetists preceded anesthesiologists as administrators of anesthesia and, historically, nurses or nurse anesthetists have been the primary providers of anesthesia services to patients in hospitals. This practice is consistent with the traditional distinction of medical treatment: physicians provide the cure component and nurses provide the care component. Moreover, studies show that nurse anesthetists administer anesthesia with the same high rate of success as anesthesiologists. Today, more than 50% of anesthesia care is provided by nurse anesthetists.

The AANA has not been a party to this litigation. It is concerned, however, that the role and capabilities of nurse anesthetists have been incorrectly described in both the District Court and Court of Appeals decisions. These misconceptions resulted because the role of nurse anesthetists was incorrectly presented at the trial by the parties, a hospital and an anesthesiologist. Moreover, the witnesses at the trial did not include representatives of the nurse anesthetists. From the transcript of the trial court proceedings and the District and Appellate Court decisions, it is easily seen that the court was not familiar with the role that nurse anesthetists play in the administration of anesthetics.

The AANA has not adopted a position with regard to the propriety of exclusive contracts between hospitals and anes-

thesiologists. Nevertheless, since none of the parties to this litigation represent the interests of the AANA nor the 23,000 CRNAs who are its constituent members, the AANA feels obliged to set forth facts that have not heretofore been adequately presented in this action.

This brief is submitted to provide the Court with information regarding the historic and contemporary role of the nurse anesthetist as a fully qualified administrator of anesthesia. This viewpoint, omitted in the lower court proceedings, is essential for a complete understanding and a fair portrayal of the way in which the health care industry provides for the administration of anesthesia care.

Furthermore, because of the potentially different interests of CRNAs and anesthesiologists, the AANA requests that the Court limit its findings and decision in this case to anesthesiologists, recognizing that circumstances regarding nurse anesthetists, which are not properly before the Court, may be different.

Summary of the Argument.

The AANA calls the Court's attention to a number of facts relating to the historic and contemporary role of nurse anesthetists which have been omitted or incorrectly presented in the lower courts.

In particular, the Court should be aware that nurse anesthetists have been administering anesthesia for more than a century. In addition, more than half of anesthesia services in the United States are administered by nurse anesthetists and studies show that they do so with the same high degree of quality as anesthesiologists.

The AANA was not a party to this litigation and did not participate either in the trial or appeal to the Fifth Circuit Court

of Appeals. While it takes no position as to the merits of the action, it urges the Court to strictly limit its decision to the specific issues raised by the parties to this litigation. The Court should be particularly cognizant that the issues in this matter relate to staff privileges for anesthesiologists, and issues relating to nurse anesthetists, *who are not before the Court*, may be entirely different.

Argument.

I. Historically, Nurse Anesthetists Preceded Anesthesiologists as Administrators of Anesthesia.

In its *amicus* brief before the Fifth Circuit Court of Appeals, the American Society of Anesthesiologists noted that "the emergence of anesthesiology as a distinct medical specialty has been a comparatively recent development. . . ." (Brief of *Amicus Curiae* of the American Society of Anesthesiologists at 3.) In fact, nurses were the first group from which members were consistently trained as anesthetists (I. Gunn, "Nurse Anesthetist — Anesthesiologist Relationships: Past, Present, and Implications for the Future," 43 AANA Journal No. 2, April 1975 at 131). Thus, it was nurse anesthetists who preceded anesthesiologists.

The development of a physician specialty devoted to anesthesiology is quite recent. The American Society of Anesthesiologists was not formed until 1937. At that time, there were only ten anesthesiology residency programs in the entire United States (Adriani, 51 Anesthesia and Analgesia No. 5, September/October, 1972). By 1940, there were only 1,000 members of the American Society of Anesthesiologists (Hingson, 46 Anesthesia and Analgesia No. 1, January/February

1967). On the other hand, nurses were administering anesthetics long before the turn of the century. A professional organization of nurse anesthetists was formed in 1931 and in 1952, it became the accrediting agency of the United States Office of Education for programs and schools of nursing anesthesia (I. Gunn, *supra*). In contrast, prior to 1968, a physician was classified as an "anesthesiologist" merely by self-designation (F. Orkin, M.D., Studies of Anesthesia Manpower, *Health Care Delivery in Anesthesia* (1980) at 123).

Courts have long supported the administration of anesthesia by nurses. In *Frank* v. *South*, 175 Ky. 416, 194 S.W. 375 (App. Ct. Ky. 1917), the court ruled that a nurse giving anesthesia is not engaged in the practice of medicine within the meaning of the statute. The court in *Chalmers-Francis* v. *Nelson*, 6 Cal.2d 402, 57 P.2d 1312 (1936), held that a nurse delivering an anesthetic under a surgeon's direction during surgery is not "diagnosing or prescribing" within the meaning of the California Medical Practice Act. Similarly, in *State* v. *Borah*, 51 Ariz. 318, 76 P.2d 757 (1938), the court held that registered nurses may administer anesthetics under the direction of, and in the immediate presence of, a licensed dental surgeon.

Thus, a brief review of the history of anesthesiology demonstrates the long-standing tradition of the administration of anesthesia by nurse anesthetists and the recent development of physicians specializing in the field of anesthesiology.

The history of the role of nurse anesthetists in delivering anesthetics is also consistent with the traditional distinction between medicine and nursing. The traditional philosophy of medicine has been that physicians provide the cure component of the treatment and that nurses provide the care component. Cure is often characterized by the functions of diagnosis and its treatment. Anesthesia, except for a minimal number of diagnostic or therapeutic aspects, is not perceived as *primarily* diagnostic or therapeutic. Thus, it does not fit well into the

cure model even though at times it gives occasion for diagnosis and treatment.

> Anesthesia is basically a process through which patients are rendered insensitive to pain, with or without unconsciousness, and often temporarily paralyzed to facilitate other medical requirements. As a result of the process, the patient is rendered incapable of caring for himself. Thus, the care component becomes critical to the process, mandating vigilance in monitoring aimed at protecting and detecting changes requiring modification of the process to maintain the patient at near optimal status. This is and has been a traditional nursing function. (I. Gunn, Professional Territoriality and the Anesthesia Experience, *Nursing Issues and Nursing Strategies for the 80's*, publication in May, 1983.)

II. Certified Registered Nurse Anesthetists (CRNAs) are Highly Educated and Must Continuously Demonstrate their Ability and Education in Bi-Annual Recertification Programs.

The basic curriculum of an accredited nurse anesthesia educational program in the United States requires twenty-four months of study and is offered at baccalaureate and masters degree levels or as a certificate-granting program. Licensed professional nurses entering these programs must have a minimum of one year of nursing experience in an acute care setting. However, the typical applicant has at least two years of nursing experience in an intensive care unit.

Upon graduation from a nurse anesthesia educational program, accredited by the Council on Accreditation of Nurse

Anesthesia Educational Programs/Schools, an autonomous body composed of anesthesiologists, nurse anesthetists and representatives of the public, a licensed professional nurse is eligible to become a CRNA. In order to obtain certification, the applicant must successfully write a national examination administered by another autonomous body, the Council on Certification of Nurse Anesthetists. *See, Anesthesia and the Law*, edited by Peters, Fineberg, Kroll and Collins (1983).

A CRNA must also maintain certification through a recertification process administered by the Council on Recertification of Nurse Anesthetists of the AANA. This process requires that every two years each CRNA demonstrate evidence of: (1) current licensure as a registered nurse; (2) active practice as a nurse anesthetist; and (3) appropriate continuing education within the speciality. *Anesthesia and the Law, supra.*

III. Nurse Anesthetists Administer Anesthesia with the Same High Level of Results as Anesthesiologists.

As noted above, anesthesia services are sometimes provided by nurse anesthetists and sometimes by anesthesiologists. Studies of mortality rates related to the use of anesthesia have indicated that there is no significant difference in the quality of care delivered by anesthesiologists and nurse anesthetists. *See,* W. Forrest, Outcome — The Effect of the Provider, *Health Care Delivery in Anesthesia* (1980), at 141: "Thus, using conservative statistical methods, we conclude that there were no significant differences in outcomes between the two groups of hospitals defined by type of anesthesia provider" (referring to hospitals in which anesthesiologists primarily were the providers and hospitals where nurse anesthetists were primarily the providers); A. Bechtoldt, "Committee on Anesthesia Study, Anesthesia Related Deaths, 1969-1976," 42 N.C. Med. J. No. 4, April 1981 at 257: "Therefore, when we calculated the in-

cidence of anesthetic related deaths for each group which administered the anesthetic . . . we found that the incidence among the three major groups (the CRNA, the anesthesiologists, and the combination of CRNA and anesthesiologists) to be rather similar." *See also, Health Care Delivery in Anesthesia,* edited by Hirsch, Forrest, Orkin and Wollman (1980) at 220: "It was surprising that the stage of training of the anesthesiologist or administration of an anesthetic by a nurse anesthetist or anesthesiologist seemed to affect risk very little. . . ."

In short, these studies show that, contrary to the impression given to the trial court judge, there is no difference in outcome whether the provider is a nurse anesthetist or an anesthesiologist. The studies reflect no difference in patient care or mortality rates. Implications in the trial transcript and lower court decisions that nurse anesthetists provide lower standards of health care are factually incorrect and misleading (W. Forrest, *supra*; A. Bechtoldt, *supra*).

IV. Nurse Anesthetists Practice in Every State and Provide More than 50% of Anesthesia Services in the United States.

The field of anesthesiology in today's hospitals is composed of both anesthesiologists and nurse anesthetists. More than 50% of anesthesia services are provided by nurse anesthetists who practice in collaboration with, or under the direction of, physicians, dentists, and other health professionals. In rural areas where there are fewer anesthesiologists, nurse anesthetists provide more than 70% of the anesthesia care. (AANA Summary to Accompany "Certified Registered Nurse Anesthetist (CRNA) Reinbursement Legislation.")

Not only does every state in the country recognize the role of nurse anesthetists and authorize them to provide anesthesia services, thirty-four states identify nurse anesthetists as ad-

vanced or expanded-role professional nurses. In short, the administration of anesthesia by nurse anesthetists is a widespread and acceptable practice in the health profession.

While most anesthesiologists are either self-employed or work in group practices, the same is not true of CRNAs. Indeed, almost 60% of CRNAs are employed within hospitals while 30% are employed by physicians, 5% are employed by the military, veterans and public health hospitals and only 5% are self-employed. The median annual earnings of CRNAs is approximately $27,750 as compared to anesthesiologists, whose median is $110,000 (as reported by the Health Care Financing Administration). AANA Summary, *supra*.

Twenty-four Blue Cross/Blue Shield plans (representing over 30% of all Blue Cross/Blue Shield plans) directly reimburse CRNAs. Eight states permit reimbursement of CRNAs directly through Medicaid programs. Of the private insurance plans surveyed by AANA, 57% indicate that they can provide direct reimbursement to CRNAs for anesthesia services. AANA Summary, *supra*.

V. The Lack of Participation by Nurse Anesthetists in the Trial is Reflected in Misunderstandings Concerning the Role of the Nurse Anesthetist Which are Reflected in the Transcript of the Trial Court Proceedings, and in the District and Appellate Court Decisions.

It is a basic tenet of our legal system that a party will not be bound by a court proceeding unless the party has had the opportunity to be represented at the proceeding. The instant action presents this Court with a dispute between a hospital and an anesthesiologist seeking admission to practice at the hospital. Testimony at the trial was provided by hospital administrators, anesthesiologists and expert witnesses, but no repre-

sentatives of nurse anesthetists participated. The reason for this is obvious. The dispute was between a hospital and an anesthesiologist and did not directly concern nurse anesthetists.

Nevertheless, during the course of the trial, there was a significant amount of testimony regarding the role of nurse anesthetists and how their professional function interrelates with the services provided by anesthesiologists. Unfortunately, much of this testimony was misleading or incorrect and was provided either by persons without expert knowledge or by persons who had an adverse position to advocate. The trial court apparently took the erroneous view that anesthesiologists could speak for everyone providing anesthesia services while the facts do not support this conclusion. Moreover, there was no representative of nurse anesthetists at the trial to challenge the assertions made by the various witnesses.

The resulting opinions of the District and Appellate Courts have also incorporated the incorrect assertions about the role and history of nurse anesthetists. The purpose of this brief, therefore, is to call this Court's attention to some of the incorrect or misleading material contained in these lower court papers so that it will not be perpetuated in the opinion which is to be rendered by the Court in this matter.

A. *Proceedings in the District Court.*

The trial court acted upon several fundamental misconceptions about CRNAs, both during the trial of this action and in its decision. Some of the more egregious examples of those misconceptions, as well as certain biased, inaccurate or misleading testimony about CRNAs, are set forth herein.

Judge Mitchell quite apparently viewed the use of CRNAs as being tantamount to fraud. He termed the hospital's practice of providing services by CRNAs under anesthesiologist super-

vision, while billing as if an anesthesiologist had performed the procedure, as a "shoddy practice" (Tr. Vol. IA at 52)[1] and a "ripoff" of the patient (Tr. Vol. IA at 54). Had Judge Mitchell's statements been limited to the financial aspect of this arrangement, the AANA would perhaps not take exception to it, but further reading of the record reveals the actual basis for the court's perception.

The following colloquy between Judge Mitchell and Mose Ellis, the administrator of East Jefferson General Hospital, is illustrative:

> THE WITNESS: . . . if ever anesthesia were given by M.D. anesthesiologists . . . compared to the present system. . ., costs would surely go up higher than right now.
> THE COURT: The standard of medical care would go up, too.
> THE WITNESS: I think the standard of medical care would go up, but we are talking about costs now. . . .
> THE COURT: Surely from a medical standpoint, isn't that the ideal situation? Wouldn't you prefer having an M.D. anesthesiologist administer an anesthetic rather than a nurse?
> THE WITNESS: I know me, I would.
> THE COURT: I have had several operations and I understood that an M.D. anesthesiologist attended me. Now I know. Now I know that that was not so.

(Tr. Vol. IA at 64-66.)

Thus, Mr. Ellis, who was neither a medical doctor nor had any medical training or responsibilities (Tr. Vol. IA at 4) and who was not qualified as a witness as to standards of anesthesia

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[1] Citations in this form are to the transcript of the District Court proceedings as no joint appendix was available to the amicus.

practice, was permitted, and in fact encouraged, to assert his private opinions and his preference for M.D. anesthesia over nurse anesthesia. Mr. Ellis also testified to his opinion that a complete substitution of CRNAs for M.D. anesthesiologists would result in a reduction of patient care (Tr. Vol. IA at 57-58). Such opinion testimony was repeatedly accepted as fact by the trial judge, who continued to express his private preference for M.D. anesthesia.

The judge went on to state: "I'll tell you one thing, if I have to have another operation, I'm going to get me a guard to stand there and guard the anesthesiologist and not let him out of the room because I'm tired of you ripping off the citizens." (Tr. Vol. IB at 11.)

Mr. Ellis was aware that there was an alternative view, but in the absence of participation by CRNAs, this material was not further explored. Mr. Ellis testified that:

> However, I will tell you that our surgeons have been questioned over and over and over again for nine years about the quality of the service, and because — especially every time we have been talking about a new contract. We get a unanimous feeling from them that they are very happy with the quality of service and every one of their cases they shift essentially, the anesthesia is given by the nurse anesthetists.

(Tr. Vol. IA at 70.)

The depth of the trial court's misperception of the facts is graphically illustrated by the following discussion between the judge and Mr. Ellis:

> THE COURT: Why don't we just do away with physician anesthesiologists and say, all right, just nurses do it from now on?

THE WITNESS: That would be a reduction in quality of care.

THE COURT: You would kill a lot of people, wouldn't you?

THE WITNESS: It would be a reduction in quality.

THE COURT: That's for sure.

(Tr. Vol. 1A at 50.)

In his zeal to denigrate a proud and competent profession, the judge states, totally without basis, that care by well-educated, dedicated and experienced professionals will lead to needless patient fatalities. This profession deserves far better treatment than it has received. Indeed, had the trial court's obvious bias not foreclosed further inquiry, it would have been apparent, as the studies cited in this brief make clear, (*supra* Argument III at 7-8) that mortality rates and the quality of care are not affected by the identity of the anesthesia provider.

Later in Mr. Ellis' testimony, both counsel for the plaintiff and the court demanded to know: "who set the standard of allowing nurses to give anesthesia?" (Tr. Vol. IA at 75.)

The actual historical development of nurse anesthesia (and the fact that anesthesiologists are relative late-comers to the profession) was never really explained to the court, although evidence of that development and the professional standing of CRNAs was known and readily available to the parties through authoritative sources such as those cited in this brief.

Neither was the court informed of the demanding education, licensure and certification procedures which the modern CRNA has undergone. Rather, the court was permitted to continue in its mistaken belief that nurse anesthetists represent a pragmatic and somewhat second-best interim solution to an alleged shortage of anesthesiologists.

The respective professional competence of anesthesiologists and of CRNAs was not, or should not have been, at issue in this case. As the studies cited above indicate, CRNAs can and do practice with the same high level of care as anesthesiologists (W. Forrest, *supra*; A. Bechtoldt, *supra*; F. Orkin, *supra*). Yet this issue, and Judge Mitchell's emotional reaction to it, was permitted by the court and by counsel to dominate the proceedings.

The opinion testimony of the one expert witness called during the trial of this action, an anesthesiologist, was unsupported and self-serving. Dr. John Adriani testified that his long-term intention in setting up a residence program for anesthesiologists at Charity Hospital in New Orleans was "the idea of one day eliminating the CRNAs." (Tr. Vol. II at 45.)

Notwithstanding that the issue of whether nurse anesthetists practice medicine had been decided by the courts sixty years before and that CRNAs practiced in all fifty states, the trial judge and Dr. Adriani engaged in the following colloquy:

> THE COURT: Don't some states require that the anesthesiologist be a medical doctor?
> THE WITNESS: Yes. Anesthesiology is considered the practice of medicine.
> THE COURT: That's right.
> THE WITNESS: A nurse can't practice medicine.
> THE COURT: It looks to me like they're delegating the field of anesthesiology by turning it over to the nurse.
> THE WITNESS: They have. That's exactly the point that I'm trying to make.

(Tr. Vol. II at 36.)

B. *The District and Appeals Court Decisions.*

The opinions in the lower courts in this matter have also incorporated some of the erroneous and misleading testimony which was adduced at trial. This testimony is particularly offensive where it reflects poorly on the quality of care provided by nurse anesthetists, especially since the CRNAs did not have the opportunity to present evidence to the court or cross-examine the witnesses. Some of the more obvious examples follow.

Dr. Charles Eckert, an anesthesiologist employed by the group of anesthesiologists contracted to practice at East Jefferson General Hospital, testified at the trial. The District Court referred to his testimony in its opinion as follows:

> Eckert testified that there are one hundred fifty-six anesthesiologists in Louisiana and three hundred forty-five hospitals with operating rooms. He testified that in order to have an anesthesiologist present at every operation, East Jefferson would have to employ more than twelve anesthesiologists on its staff.

Hyde v. *Jefferson Parish Hospital District No. 2*, 513 F. Supp. 532, 538 (E.D. La. 1981).

This statement implies that it is desirable to have an anesthesiologist, as opposed to a nurse anesthetist, present at every operation. The trial court gave the impression that the only reason this could not be accomplished was a shortage of anesthesiologists.

This implication is based on a faulty premise. It fails to acknowledge the fundamental role of the nurse anesthetists. In particular, it overlooks the fact that nurse anesthetists did not evolve as a result of a shortage of anesthesiologists. Rather, they were administering anesthesia many years prior to the emergence of anesthesiologists. To suggest otherwise denigrates the important functions historically performed by nurse anesthetists.

Some of the above testimony presented to the trial court was also adopted by the Fifth Circuit Court of Appeals and incorporated into its opinion. One of the most obviously misleading impressions adopted by the Appeals Court is reflected in the following excerpt from its opinion: "Another twist which is important to an understanding of the specialty is that more than in any other medical specialty, anesthesiologists have been confronted with the growth of a paraprofessional counterpart — the anesthetist." *Hyde* v. *Jefferson Parish Hospital District No. 2*, 686 F.2d 286, 291 (5th Cir. 1982.)

The trend noted by the court is presented in precisely the reverse order. Anesthesiologists emerged in a field dominated by nurse anesthetists and have thereby developed their specialty in an area which was historically a non-physician domain.

An even more offensive misstatement of facts is incorporated in a later portion of the opinion of the Appeals Court.

> Quality is lowered by this restraint while at the same time the hospital's profit, as demonstrated above, is raised. In the instant case, there was also testimony that the profit motive caused the hospital to hire nurse anesthetists in place of needed anesthesiologists, a practice which dilutes the professional coverage available.

686 F.2d at 292.

First, there is absolutely no evidence that "quality is lowered" when anesthesia is administered by nurse anesthetists rather than by anesthesiologists. The court assumes that a longer-educated individual can perform a function better because of his or her longer education. This assumption is not necessarily true. In the case of administering anesthesia, it is simply not true at all. The studies cited above clearly demonstrate that the quality of care is of the same high standard

when anesthesia is administered by nurse anesthetists rather than anesthesiologists.

Second, hospitals do not hire nurse anesthetists "in place of needed anesthesiologists." Hospitals employ nurse anesthetists because they are well educated and effective in administering high quality anesthesia care.

Conclusion.

The AANA does not take a position on the merits of this action. Moreover, the AANA believes that the foregoing factual issues are not necessarily relevant to the legal issues to be decided in this matter. Nor does the AANA take the position that the foregoing errors of fact lead to an erroneous legal conclusion. However, the AANA submits to this Court that the lower court proceedings and opinions erroneously portray the role of the nurse anesthetist and detract from the professional reputation established by nurse anesthetists throughout the country over many years.

The AANA respectfully submits to this Court that the foregoing represents merely a brief examination of the conflicting and collaborative roles of anesthesiologists and nurse anesthetists. The trial court and the Circuit Court of Appeals rendered opinions and conclusions regarding these roles without the opportunity to consider testimony from the nurse anesthetists. Therefore, both courts reached a number of erroneous conclusions. The AANA urges this Court to review the facts outlined herein so that it will not repeat the factual errors of the lower courts.

Further, the AANA requests that this Court strictly limit its decision to the parties and the issues raised at the trial. In particular, this Court should be cognizant that the circumstances

of this action relate to anesthesiologists. Issues relating to nurse anesthetists, who are not before this Court, may be entirely different. This Court must recognize that the factual issues are complex; that the evidence in the record relating to the field of anesthesia was not complete; and that the impact on the health care industry of any decision of this Court without sufficient facts may produce unintended results. Therefore, we urge this Court to limit its decision so as not to impact upon areas of the health care field not represented in the trial court proceedings.

Finally, this Court should not assume that the delivery of quality anesthesia care is dependent on whether the provider is an anesthesiologist or a nurse anesthetist. The studies produced by qualified professionals clearly demonstrate that the identity of the anesthesia provider does not effect the quality of the service provided.

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2
and EAST JEFFERSON HOSPITAL BOARD,
Petitioners,

v.

EDWIN G. HYDE,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF AMICUS CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF THE PETITIONERS

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QUESTION PRESENTED

Whether an arrangement by which a hospital chooses only one group of physicians to render all anesthesia services at the hospital is a *per se* illegal tying arrangement under Section 1 of the Sherman Act, 15 U.S.C. § 1 (1976).

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No. 82-1031

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2
and EAST JEFFERSON HOSPITAL BOARD,
Petitioners,

v.

EDWIN G. HYDE,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF AMICUS CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF THE PETITIONERS

INTEREST OF THE AMERICAN HOSPITAL ASSOCIATION

Amicus Curiae American Hospital Association respectfully presents this brief in support of the Petitioners on the merits of the instant matter. The American Hospital Association has obtained the written consent of both the Petitioners and the Respondent to the filing of this *amicus curiae* brief.

The American Hospital Association ("AHA") is the primary organization of hospitals in the United States. It is a not-for-profit membership corporation organized under the laws of the State of Illinois. The principal corporate objective of the AHA is "to promote the welfare of the public through its leadership and its assistance to its members in the provision of better health services for all people." Its membership includes approximately 6,300 hospitals and other health care in-

The AHA has an historical commitment to the principle of quality health care for hospital patients, while recognizing that the containment of hospital costs is vital to the continued ability of hospitals to provide that quality care. Hence, the AHA traditionally has undertaken to assist its members in their efforts to achieve the delivery of cost-effective, high quality health care services. Because a hospital itself obviously is not a practitioner of medicine, its relationships with physicians are of critical importance to its success in achieving that goal, and to the ability of the hospital's governing board to discharge its own ultimate responsibility—imposed by federal Medicare program participation requirements, by voluntary accreditation standards, and, increasingly, by common law—for the composition and services of its medical staff.

The AHA recognizes that sound medical care is being provided in hospitals by physicians under a variety of staffing arrangements and does not recommend or endorse any specific arrangement as the best means in all circumstances to provide hospital or medical services. *See* American Hospital Association, *Guidelines: Contractual Relationships Between Hospitals and Physicians* (1976). However, many of AHA's member hospitals, in the exercise of their professional judgment, maintain exclusive arrangements with physicians as a means to serve important interests of the hospital and the community, and confer significant benefits on patients. Exclusive arrangements are particularly prevalent with respect to the provision of necessary, "ancillary" hospital services—anesthesiology, radiology, pathology and emergency room services—for the availability and quality of which hospitals bear an independent and judicially-recognized accountability to their patients.

The AHA further believes that an exclusive arrangement of the type at issue in this case also can serve to foster, rather than inhibit, competition in the health care marketplace. Consequently, the AHA strongly supports the right of hospitals to

maintain the flexibility to enter into an exclusive arrangement with a physician or physician group if the hospital determines that such a staffing arrangement best allows it to serve the interests of its patients. The decision below, through the automatic application of the *per se* rule in this setting, is erroneous, and improperly interferes with that flexibility.

SUMMARY OF THE ARGUMENT

Exclusive staffing arrangements are used extensively by hospitals in the provision of anesthesiology and other necessary hospital-based medical services, and can be critical to hospitals' ability to discharge recognized legal obligations toward their patients and to provide cost-effective, quality patient care.

Amicus curiae American Hospital Association respectfully submits that the judgment of the United States Court of Appeals for the Fifth Circuit, declaring invalid an exclusive staffing arrangement for the provision of anesthesiology services, is erroneous and should be reversed for several reasons. First, the court below erred in finding that the arrangement at issue is a tying arrangement, in that only one product—surgical procedures— actually is being sold. Second, the decision conflicts with previous decisions of this Court with respect to the circumstances in which the *per se* standard of antitrust analysis should apply, because the type of arrangement here can result in a productively efficient and procompetitive type of vertical integration and is not a "naked restraint of trade." Third, the Fifth Circuit erred in finding that the hospital had appreciable economic power in the market for the alleged tying product and therefore erred in finding a *per se* violation of Section 1 of the Sherman Act.

ARGUMENT

I. Introduction—Importance Of Exclusive Staffing Arrangements To The Hospital Field

a. In General

As recognized by the district court below, as well as other courts that have considered exclusive arrangements of the type at issue herein, the use of such arrangements is widespread within the hospital field. 513 F. Supp. 532, 540 (E.D. La. 1981) (it is a "common practice in the health care industry for hospitals to enter into exclusive contracts with physicians"). *See also Dos Santos* v. *Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346, 1351 (7th Cir. 1982) ("exclusive dealing arrangement[s] ... [have] been adopted by most hospitals in the Chicago area").

The prevalence of exclusive arrangements reflects both growing specialization and increasing sophistication in the delivery of medical services, as well as the ability of the arrangements to address important needs with respect to the delivery of such services. Specifically, such arrangements allow hospitals to secure and maintain continuously available, high quality medical services; to secure administrative services necessary to the effective and efficient operation of the subject department; and to lower the hospital's operating costs.

Hospitals today inevitably must utilize contractual arrangements, many of which are exclusive in nature, to ensure the provision of an increasing number of medical specialty services including, among others, nuclear medicine, renal dialysis and cardiac catheterization. However, the use of exclusive arrangements is especially prevalent nationwide with respect to the provision of hospital-based ancillary services—anesthesiology, radiology, pathology and emergency room services. As their name implies, ancillary services are provided in support of the primary service for which the patient is in the hospital. For example, anesthesia is one of the many services that are essential but 'ancillary' to the provision of the surgical services

for which the patient has been admitted, and thus is viewed by most patients as part of the surgical procedure. Patients in fact do not choose the physicians or other health professionals who will provide those necessary ancillary care services. *See Dos Santos*, 684 F.2d at 1354; *United States* v. *American Society of Anesthesiologists*, 473 F. Supp. 147, 160 (S.D.N.Y. 1979) ("there is unrefuted evidence that the patient is not truly a customer of the anesthesiologist"). Instead, they rely upon others—e.g., their individual surgeons and, ultimately, the hospital itself—both to make informed choices of ancillary care physicians for them, and, in effect, to vouch for the quality of the services provided.

The necessity of the ancillary services, combined with the absence of physician selection by the patient, has led courts to recognize the special legal obligation of the hospital to ensure the availability and quality of those services. *E.g.*, *Dos Santos*, 684 F.2d at 1354; *Capili* v. *Shott*, 487 F. Supp. 710, 712 (S.D. W. Va. 1978), *aff'd*, 620 F.2d 438 (4th Cir. 1980) ("[t]hese are the services a hospital must guarantee as available to all patients ...[;] [b]ecause the hospital patients do not select the physicians rendering these services and generally do not even know the names or qualifications of these physicians, the hospital has a greater burden of responsibility in assuring the proper quality and quantity of such services"). *Cf. Smith* v. *Northern Michigan Hospitals, Inc.*, [1983-1] Trade Cas. (CCH) ¶ 65,289, at 69,708 (6th Cir. Mar. 25, 1983) (the hospital, "as the coordinator and supplier of an essential ... public service, ... not only may, but also is obliged, to staff its limited [emergency] facilities in the manner which best serves the public interest"). *See also* HHS Medicare Conditions of Participation, 42 C.F.R. § 405.1011 *et seq.* (1977); Joint Commission on Accreditation of Hospitals ("JCAH"), *Accreditation Manual for Hospitals* (1982), for specific requirements imposed on hospitals for the provision of ancillary medical services.

b. Quality and Efficiency Benefits

Many hospitals have determined that, in light of their own individual circumstances and experience, exclusive arrangements provide the most effective and often the *only* means to ensure both the continuous availability of medical services and the quality of those services. One essential characteristic of exclusive arrangements between hospitals and physicians is precisely that the physicians contractually guarantee the hospital twenty-four hour coverage of the subject service as a necessary aspect of their responsibility, which in turn requires or makes desirable that the physicians' relationship be an exclusive one. Physicians cannot feasibly provide assurances of coverage or quality where the service responsibilities are fragmented.

In the absence of a contractual guarantee of continuous coverage, a hospital is likely to experience situations where anesthesiologists, for example, are unavailable for surgery either because of sickness, vacation, or time limitations. *See Capili*, 487 F. Supp. at 711, 712 (prior to contracting exclusively, hospital attempted to ensure coverage through "on call" services of anesthesiologists, which proved "inadequate to insure proper patient care"; JCAH annual review of hospital under "on call" arrangement indicated "deficiencies" in provision of anesthesia services). As specifically found by the district court in the instant case, an exclusive arrangement assures the hospital twenty-four hour coverage of the subject service, 513 F. Supp. at 540; *see also, e.g., Dos Santos*, 684 F.2d at 1351; *Capili*, 487 F. Supp. at 712, and thus assists the hospital both to ensure proper patient care and to avoid potential liability based on inadequate rendering of that care.

In addition, courts (including the district court below), commentators and hospitals have recognized that exclusive arrangements produce numerous other, specific patient care and efficiency-related benefits which may be unattainable except by use of an exclusive arrangement but which also are

crucial to the hospital's ability to discharge its own responsibilities concerning the quality and availability of medical services. *See generally* M. Pollard & R. Leibenluft, *Antitrust and the Health Professions; Policy Planning Issues Paper* (Federal Trade Commission, 1981); Foster, *Exclusive Arrangements Between Hospitals and Physicians: Antitrust's Next Frontier in Health?*, 26 St. Louis U.L.J. 535 (1982). In general, those benefits flow from the exclusive contract's specific provision for the unified responsibility and accountability of a limited number of physicians to the hospital's governing board for the quality of all services rendered, as well as the physicians' typical contractual responsibility for the complete management of the hospital department, including the provision of supervisory, training and administrative services essential to the most effective and efficient delivery of the subject service.

Among the many additional benefits resulting from an exclusive arrangement between a hospital and a physician group is the hospital's increased ability to monitor continuously the performance of the contracting physicians to ensure that medical quality standards are being met. *See, e.g.*, M. Pollard & R. Leibenluft, *supra*, at 97; Foster, *supra*. Also, the exclusive arrangement often serves to foster greater physician competence, due to increased specialization with attendant development of skills through repetition of specialized procedures. *Id.*

In addition, because the terms of exclusive arrangements typically are for short periods of time and/or are terminable on short notice, a hospital dissatisfied with the performance of the contracting physicians can terminate the arrangement and contract with others. *Cf. Dos Santos*, 684 F.2d at 1354 (exclusive arrangements "may also serve to benefit competition among anesthesiology groups[,] . . . encourag[ing] anesthesiologists to improve the quality of their services in order to obtain these contracts") (quoting the district court herein, 513 F. Supp. at 541).

Further, caselaw emphasizes that exclusive arrangements facilitate improved scheduling in the use of facilities and support staff. *E.g., Capili*, 487 F. Supp. at 712 ("advantages of the exclusive arrangement [for provision of anesthesia services] ... included the efficient scheduling of surgery"). Procedures are done best, most reliably and most efficiently when access to facilities and equipment is planned in advance. Such planning typically is one of the specific contractual obligations of the physician group, and is simplified when coordinated through that single group. For example, a hospital that maintains an exclusive arrangement with an anesthesiology group secures unified responsibility for the scheduling of operating room usage, effectively minimizing the delays and conflicts that arise when a hospital must accommodate the personal scheduling wishes of multiple independent practitioners.

Exclusive arrangements also provide greater control and standardization of procedures, thereby allowing lower operating costs. *See, e.g.*, M. Pollard & R. Leibenluft, *supra*, at 97; Foster, *supra*. More effective selection, use and maintenance of equipment also results. *See, e.g., Capili*, 487 F. Supp. at 712 ("advantages of the exclusive arrangement ... included ... the uniform selection and use of anesthesia equipment and gasses"). For example, the use of costly and sophisticated equipment by only one group tends to minimize the number of equipment breakdowns and facilitates recognition and remedy of malfunctions that do occur. Further, an exclusive arrangement directly facilitates improved work routines and teamwork because physicians both work consistently with and have a specific contractual obligation to supervise a particular group of nurses and technicians, whose services also are crucial to the effective and efficient delivery of the subject service. *See generally* M. Pollard & R. Leibenluft, *supra*, at 97; Foster, *supra*.

Finally, then, and as a result of the many benefits discussed above, the hospital is able to earn an enhanced reputation for

excellence, thus enabling it to attract top flight physicians. *Id.* Given the increased willingness of courts to hold hospitals liable for negligently granting staff privileges to unqualified physicians, *see, e.g., Elam* v. *College Park Hospital,* 183 Cal. Rptr. 156 (Cal. App. 1982), this consideration is particularly important if the hospital is to minimize its vulnerability to malpractice litigation. In addition, however, the ability of the hospital to compete also is enhanced given that hospitals traditionally have competed on a non-price basis to provide the best *quality* of patient care. *E.g., Robinson* v. *Magovern,* 521 F. Supp. 842, 919 (W.D. Pa. 1981), *aff'd mem.,* 688 F.2d 824 (3d Cir.), *cert. denied,* 103 S. Ct. 302 (1982) (closed staff system may promote competition among hospitals resulting in improved quality of patient care). *See Dos Santos,* 684 F.2d at 1354 ("competition among the hospitals in the market [may be enhanced] by increasing the quality of medical care available") (quoting the decision of the district court herein, 513 F. Supp. at 541).

Thus, it is apparent that a hospital has a strong independent interest in maintaining exclusive arrangements with physicians. Demonstrable benefits obtained by the use of such arrangements directly assist the hospital to discharge its legal and professional obligation to its patients to ensure continuously available, high quality health care, and assist it to compete effectively with other hospitals.

II. The Fifth Circuit Erred In Characterizing The Alleged Restraint As A Tying Arrangement

a. A pragmatic economic examination of the agreement between the hospital and the anesthesiology group shows that the Fifth Circuit erred fundamentally in characterizing the arrangement as a tying agreement rather than as an exclusive dealing contract. The hospital, which is responsible for ensuring the provision and quality of anesthesia services, serves as an agent on behalf of its surgical patients to choose the supplier of one component used to produce the service desired by its

patients—that is, surgical procedures. *Cf. Dos Santos*, 684 F.2d at 1354 ("[i]t may ... be more appropriate for antitrust purposes to treat the *hospital* as the purchaser" of anesthesia services because, *inter alia*, the patient generally takes no part in selection of anesthesiologist and hospital bears a legal responsibility for the availability and quality of the services rendered). The arrangement promotes efficiency in the purchase and delivery of anesthesia services and ensures that patients, who typically are unable to choose their anesthesiologist, are served by highly qualified professionals.

Determining the nature of the alleged restraint is a crucial first step because "the characterization of a practice as a requirements contract or as a tying arrangement can determine the result in a case." Baker, *The Supreme Court and the Per Se Tying Rule: Cutting the Gordian Knot*, 66 Va. L. Rev. 1235, 1308-09 (1980). Several factors should be examined in characterizing the arrangement. First, tying arrangements typically require the purchaser to buy a product that he or she ordinarily would not purchase. *See Heatransfer Corp.* v. *Volkswagenwerk, A.G.*, 553 F.2d 964 (5th Cir. 1977), *cert. denied*, 434 U.S. 1087 (1978). This factor is not present in this case because a patient has no desire to purchase the use of a hospital's surgical facilities without the services of an anesthesiologist or anesthetist.

Second, the presence of procompetitive benefits, as here, undermines the conclusion that the arrangement is a tying agreement. This is because "tying agreements serve hardly any purpose beyond the suppression of competition," *Standard Oil Co.* v. *United States*, 337 U.S. 293, 305-06 (1949), while exclusive contracts achieve efficiencies and other procompetitive benefits. *Tampa Electric Co.* v. *Nashville Coal Co.*, 365 U.S. 320 (1961). Accordingly, if the arrangement in question achieves, or has the potential to achieve, significant procompetitive benefits, then it should be analyzed as an exclusive dealing arrangement. The district court below found that the exclusive

contract did achieve such benefits. 513 F. Supp. at 540. The Fifth Circuit believed that less restrictive alternatives could achieve similar results, although there was little in the record to support this conclusion.[1]

Third, the purpose for the arrangement aids in determining whether it is an exclusive dealing agreement or a tying arrangement.[2] The focus of the tying doctrine is on "practices employed to impede competition on the merits." *Hirsh* v. *Martindale-Hubbell, Inc.*, 674 F.2d 1343 (9th Cir.), *cert. denied*, 103 S. Ct. 305 (1982). Where, as here, the purpose for the agreement is to promote quality or achieve efficiencies, the tying characterization is likely to be incorrect.[3]

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[1] The least restrictive alternative doctrine is a curious sidetrack to mainstream antitrust jurisprudence. Where the spectrum of choices a businessperson can make is *infinite*, to require the business to recognize and choose *the* least restrictive alternative, especially as judged by a court in hindsight, would appear itself to be an unreasonable restraint. *Cf.* American Motor Inns, Inc. v. Holiday Inns, Inc., 521 F. 2d 1230, 1249-50 (3d Cir. 1975) (rejecting the doctrine). *See also* Continental T.V., Inc. v. GTE Sylvania, Inc., 433 U.S. 36, 58 n.29 (1977) ("the location restriction used by Sylvania was neither the least nor the most restrictive it could have used[;] [b]ut ... a *per se* rule based on the nature of the restriction is, in general, undesirable").

[2] Examining the purpose for a practice prior to characterizing that practice does no violence to the concept of a *per se* rule. *See, e.g.*, Broadcast Music, Inc. v. Columbia Broadcasting Sys., Inc., 441 U.S. 1, 9, 19 (1979); Jacobi v. Bache & Co., Inc., 377 F. Supp. 86 (S.D.N.Y. 1974), *aff'd*, 520 F.2d 1231 (2d Cir. 1975), *cert. denied*, 423 U.S. 1053 (1976). *See also* L. Sullivan, *Handbook of the Law of Antitrust* § 74, at 199-200 (1977).

[3] The Fifth Circuit found that the hospital's rationale in using the exclusive contract was to increase its own profit. 686 F.2d at 291 & n.7. This conclusion, which rejected a specific holding of the district court to the contrary (513 F. Supp. at 544), was based only on sheer speculation and not the evidence. The evidence showed that quality of care and productive efficiency were the hospital's overriding purposes in contracting with only one group. Nevertheless, a purpose to increase profits is not an anticompetitive purpose.

Fourth, it also is relevant to consider whether any other court has characterized a contract similar to the one in question as a tying arrangement. The fact that none has at a minimum suggests that the tying characterization is improper. *See, e.g., Smith, supra; Dos Santos, supra; Harron* v. *United Hospital Center, Inc.*, 522 F.2d 1133 (4th Cir. 1975), *cert. denied*, 424 U.S. 916 (1976); *Valley Hospital Medical Center Foundation* v. *Adolph*, No. 79-3336 MRP (C.D. Cal. Mar. 2, 1981); Federal Trade Commission Advisory Opinion to Burnham Hospital, at 6-7 (Feb. 24, 1983) (rejecting a tying analysis of an exclusive contract between a hospital and a physician group). In short, there is no authority whatsoever for characterizing an exclusive dealing agreement between a hospital and a physician group as a tying arrangement.

b. A factor which shows conclusively that the arrangement is not a tying agreement is that the patient is purchasing only one service—a surgical procedure. When a patient enters a hospital for surgery, he or she has no desire to use a surgical suite without a surgeon and anesthesia services, or anesthesia services without a surgeon and an operating room. Rather, a patient desires one product—the product of a unified episode of care in which the surgical suite, surgeon, and anesthesia services (and other services as well) are component elements.[4]

Curiously, while the Fifth Circuit properly recognized that a tying arrangement requires two products, neither it nor the district court examined whether, in fact, separate products were being sold. In its findings, the district court, without analysis, stated only that anesthesia services are separate from other hospital services. 513 F. Supp. at 540. That products are physically separate or separable, however, does not mean that they are distinct products for purposes of tying analysis. *See, e.g., Hirsh*, 674 F.2d at 1348. The Fifth Circuit noted only that

[4] Indeed, as the Fifth Circuit stated, 686 F.2d at 291, the patient normally does not even select the anesthesiologist. *See also* United States v. American Soc'y of Anesthesiologists, 473 F. Supp. 147, 160 (S.D.N.Y. 1979).

the instant case "deal[s] with two distinct services which a buyer should be able to obtain separately." 686 F.2d at 289. The court did not discuss why those services should be sold separately, and no evidence whatsoever supported that conclusion. Even where constituent parts could be or are sold separately, however, it does not mean that they must or should be. For example, stereo system components can be and are sold separately; but no one would argue seriously that a firm that combines and sells its components only as a system has engaged in an illegal tie-in. Moreover, if a client hires a particular law firm, no one would argue seriously that the firm is "coercing" its client illegally to purchase separate products if the partner in charge uses and bills for the products of that firm's associates, paralegals and secretaries.

The issue of product separability is especially important to hospitals because they provide, or contract for the provision of, a plethora of goods and services. Not only do they provide for the availability of physician and paraprofessional help as in this case, but hospitals also provide for numerous other goods and services without which the aggregate hospital services desired by patients could not be produced. Such items as blood, drugs, high technology equipment, food service, and laundry service are only a few. To mandate that a hospital allow its patients to choose the supplier of their choice would result in inefficiency if not utter chaos.

In attempting to solve the issue of product separability, the courts have used various language to describe what in effect is the same question: Does selling the products together promote quality and efficiency? *See, e.g., Hirsh,* 674 F.2d at 1347 ("[w]hether the aggregation serves to facilitate competition by promoting product quality"); *Principe* v. *McDonald's Corp.,* 631 F.2d 303, 309 (4th Cir. 1980), *cert. denied,* 451 U.S. 970 (1981) (one product where products are "integral components" or "essential ingredients" of the ultimate product); *Washington Gaslight Co.* v. *Virginia Electric and Power Co.,* 438 F.2d 248, 253 (4th Cir. 1971) (only one product where the

alleged tied product is an "ancillary and necessary" part of the package being sold). *See generally* R. Bork, *The Antitrust Paradox: A Policy at War with Itself* 371 (1978) ("[t]here is no doubt that this sense of efficiency is what is behind the law's attempt to decide whether a tying arrangement exists by determining whether one product or two are being sold").[5]

It is difficult, if not impossible, to find any case or commentator who argues that exclusive contracts between hospitals and physicians do not in fact achieve significant efficiencies.[6] Indeed, the offering of specialized anesthesiology services contracted for by the hospital as part of the surgical event necessarily involves quality and efficiency considerations.

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[5] Where, as here, the products are sold in fixed proportions rather than in variable proportions, both courts and commentators acknowledge that only one product is being sold. *See, e.g.*, Bowman, *Tying Arrangements and the Leverage Problem*, 67 Yale L.J. 19, 21 (1957) ("[w]henever two products are used together in fixed proportions, such as one bolt and one nut, a cup and a saucer, or a left shoe and a right shoe, from a buyer's point of view the two together might as well be a single product"). The Ninth Circuit has recognized the importance of whether two products are used in fixed proportions by incorporating the question into its test for whether the arrangement involves separate products. *See, e.g.*, Siegel v. Chicken Delight, Inc., 448 F.2d 43, 48 (9th Cir. 1971), *cert. denied*, 405 U.S. 955 (1972); Klamath-Lake Pharm. Ass'n v. Klamath Medical Serv., [1983-1] Trade Cas. (CCH) ¶ 65,254 (9th Cir. 1983).

[6] *See, e.g.*, Dos Santos v. Columbus-Cuneo-Cabrini Medical Center, 684 F.2d 1346 (7th Cir. 1982); Foster, *Exclusive Arrangements Between Hospitals and Physicians: Antitrust's Next Frontier in Health?*, 26 St. Louis U.L.J. 535 (1982); Horan & Nord, *Application of Antitrust Law to the Health Care Delivery System*, 9 Cum. L. Rev. 684, 702 (1979); M. Pollard & R. Leibenluft, *Antitrust and the Health Professions; Policy Planning Issues Paper* 96-99 (Federal Trade Commission, 1981); Federal Trade Commission Advisory Opinion to Burnham Hospital (Feb. 24, 1983); M. Thompson, *Antitrust and the Health Care Provider* 150-58 (1979); American Hospital Association, *Comments to the Federal Trade Commission on Exclusive-Source Contractual Arrangements Between Hospitals and Physicians* (Dec. 21, 1982) (attached as Appendix A).

and supports the conclusion that only one service is involved. The district court specifically found that the contract in this case achieved improved quality and efficiency, 513 F. Supp. at 540, and the Fifth Circuit's disagreement with this holding simply is not supported by the evidence.

In sum, the lower court erred by not examining whether one or two products were being sold and by not holding that patients purchase only one service—surgical procedures. By finding two products and thus characterizing the challenged agreement as a tying arrangement, the lower court improperly exalted form over substance.

III. The Fifth Circuit Erred In Applying The *Per Se* Rule To The Arrangement Because The Contract Is Not A Naked Restraint Of Trade

a. Quite apart from whether, as a technical matter, a hospital's surgical facilities and the anesthesia services available through it can be viewed as separate services, the court below erred in applying a *per se* standard of analysis. Exclusive contracts between hospitals and physician groups can, and the one in question did, result in a productively efficient and procompetitive type of partial vertical integration.

In recent years, this Court has taken pains to explain the narrow circumstances in which a *per se* analysis is proper. The Court has held that *per se* analysis should be used only where the practice in question is a "naked restrain[t] of trade with no purpose except stifling of competition," and thus "appears to be one that would always or almost always tend to restrict competition and decrease output," *Broadcast Music, Inc.* v. *Columbia Broadcasting System, Inc.*, 441 U.S. 1, 19-20 (1979), as opposed to a practice "designed to increase economic efficiency and render markets more rather than less competitive." *Id.* (quoting *United States* v. *United States Gypsum Co.*, 438 U.S. 422, 441 n.16 (1978)).

In *Continental T.V., Inc.* v. *GTE Sylvania, Inc.*, 433 U.S. 36, 50 (1977), this Court explained that "[*p*]*er se* rules ... are appropriate only when they relate to conduct that is manifestly anticompetitive." It recognized that non-price, vertical restraints normally achieve significant redeeming virtues relevant to the analysis here, such as the promotion of efficiency, protection from products liability claims, and increased competition.

Broadcast Music and *Sylvania* warn against the mechanical and wooden approach followed by the Fifth Circuit here of labelling a practice and applying *per se* analysis without first examining the practice's likely economic impact. In *Broadcast Music*, this Court cautioned against relying on "easy labels [which] do not always supply ready answers," noting that "[l]iteralness is overly simplistic and overbroad." 441 U.S. at 9. *See also Shop and Save Food Markets, Inc.* v. *Pneumo Corp.*, 683 F.2d 27 (2d Cir.), *cert. denied*, 103 S. Ct. 450 (1982) (applying these warnings to a tying case). In *Sylvania*, the Court emphasized that, in a case challenging a non-price, vertical restraint, "departure from the rule of reason standard must be based upon demonstrable economic effect rather than ... upon formalistic line drawing." 433 U.S. at 58-59.

In neglecting these explicit warnings and applying the *per se* rule, the Fifth Circuit rejected the evidence, the district court's findings, the standard applied by other courts and the unanimous opinion of commentators, and failed to weigh properly the enhancement to efficiency and quality which the exclusive contract achieved. The evidence showed, and the district court found, significant improvements in quality of care and efficiency flowing from the contract. 513 F. Supp. at 540.

b. Every federal court which has considered an exclusive arrangement, save the Fifth Circuit in the instant case, has analyzed it under the Rule of Reason and has rejected all attempts to attach the *per se* label to an arrangement consistently found reasonable after appropriate analysis of its effects.

In *Harron* v. *United Hospital Center, Inc.*, 522 F.2d 1133 (4th Cir. 1975), *cert. denied*, 424 U.S. 916 (1976), the Fourth Circuit considered a Section 1 challenge to the hospital's exclusive arrangement for the provision of all radiology services at the hospital. The court found the challenge to be "frivolous," and remanded with instructions to dismiss the complaint "for want of a substantial federal question and a consequent lack of jurisdiction." *Id.* at 1134. *See also Capili, supra* (challenge to exclusive arrangement for provision of anesthesia services failed to show effect on interstate commerce; arrangement also was neither unreasonable nor arbitrary).

The Seventh Circuit Court of Appeals, in *Dos Santos* v. *Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346 (7th Cir. 1982), rejected an argument that the exclusive arrangement amounted to a group boycott or other *per se* violation, concluding instead that the case was "properly treated ... as one involving a vertical combination ... [which] ... must be analyzed under the Rule of Reason." *Id.* at 1352, *citing, e.g., Tampa Electric Co., supra.* Further in concluding that it had "serious question whether plaintiff ... demonstrated a reasonable likelihood of success on the merits," and thus that the preliminary injunction should be vacated, the Seventh Circuit adopted for purposes of its analysis the reasoning of the *district* court in the instant case, noting with "particular interest" that court's conclusion as to the relevant geographic market and its findings concerning the procompetitive effects of exclusive contracts. 684 F.2d at 1353-54.

Finally, in *Smith* v. *Northern Michigan Hospitals, Inc.*, [1983-1] Trade Cas. (CCH) ¶65,289 (6th Cir. Mar. 25, 1983), the Sixth Circuit affirmed a lower court judgment that a hospital's exclusive contract for emergency room services did not violate Section 1. The court held that the hospital, as the coordinator and supplier of an essential public service, was properly viewed as standing in a vertical relationship both to the contracting physicians and to the independent physicians in the service area. The court thus undertook an appropriate

balancing of what it deemed the "undisputedly legitimate financial and medical reasons" for the staffing arrangement against any "ancillary" adverse effects on practitioners, in the course of affirming judgment for the hospital on the Section 1 claims. *Id.* at 69,708. *See also Valley Hospital Medical Center Foundation, supra.*[7]

Commentators reach the same conclusion.[8] The hospital has a substantial and independent interest in who provides ancillary services to ensure quality and availability, as well as to reduce costs. "[T]he existence of substantial hospital-owned equipment and numerous hospital employees who are supervised by the physicians would appear to create a prima facie case that the hospital has a strong independent interest at stake and should be allowed to manage its affairs as it wishes." Kissam, Webber, Bigus & Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 Calif. L. Rev. 595, 665 (1982). *See also* Feldstein & Roehrig, *Medical Staff: Closed v. Open Staffing—What's at Stake?*, Hospitals (J. Am. Hosp. Ass'n), Jul. 16, 1982, at 97 (the fewer the physicians, the easier it is for a hospital to control quality).

c. In sum, exclusive contracts achieve significant quality and efficiency benefits of the type recognized by the antitrust laws, and thus prior decisions of this Court preclude application

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[7] Further, the Fifth Circuit's analysis also conflicts with decisions of the Third and Sixth Circuits, which, although involving staffing arrangements not exclusive in nature, raised similar antitrust issues, and in which Rule of Reason analysis was deemed appropriate. *See* Stella v. Mercy Hospital, No. 82-1274 (6th Cir. Oct. 25, 1982), *cert. denied*, 51 U.S.L.W. 3747 (U.S. Apr. 19, 1983); Robinson v. Magovern, 521 F. Supp. 842 (W.D. Pa. 1981), *aff'd mem.*, 688 F.2d 824 (3d Cir.), *cert. denied*, 103 S. Ct. 302 (1982). *See also* Pontius v. Children's Hospital, No. 78-987 (W.D. Pa. Dec. 20, 1982); Pao v. Holy Redeemer Hospital, 547 F. Supp. 484 (E.D. Pa. 1982).

[8] *See* note 6 *supra.*

of the *per se* rule however the agreement is characterized.[9] Indeed, the economic impact of the agreement in question here is similar to that of the agreement challenged in *Sylvania*, where this Court explained that, although intrabrand competition might be adversely affected, interbrand competition would be strengthened. In this case, the agreement may reduce the number of anesthesiologists *at this hospital* below what it might otherwise be;[10] on the other hand, the contract's effect on quality and efficiency inure to the benefit of patients and makes the hospital a more effective competitor in the market.

Accordingly, the *per se* rule simply is not applicable to an arrangement where a facial examination reveals potentially significant procompetitive effects such as those resulting from

[9] One of the most unusual aspects of the Fifth Circuit's decision is its emphasis on the hospital's use of nurse anesthetists as an anticompetitive rather than a procompetitive factor. 686 F.2d at 291 & n.8. Clearly, efficiency is enhanced when lower-cost resources are used, and no evidence exists that quality is lowered. *See Is HHS Deadening the Pain of Competition?*, Regulation, Jan./Feb. 1983, at 11. Indeed, a primary overall benefit achieved by use of exclusive arrangements, and recognized by numerous courts and commentators that have considered the issue, is the *enhancement* of quality. *See also* discussion at Section I *supra*.

[10] This was the Fifth Circuit's basis for finding that the contract was anticompetitive. 686 F.2d at 291-92. The court found two anticompetitive effects: First, anesthesiologists were excluded from "that part of the anesthesia services market which the hospital controls." *Id.* at 292. This rationale improperly reflects an overriding concern with competitors rather than competition. *See, e.g.*, Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc., 429 U.S. 477, 488 (1977). Furthermore, if the hospital's share of the market is not substantial, any effect on competition is *de minimis*. A second anticompetitive effect, according to the court, was that patients were unable to choose among different anesthesiologists. 686 F.2d at 292. This "buyer autonomy"-type of purported anticompetitive effect was specifically rejected by *Sylvania*. *See* 433 U.S. at 53 n.21. *See also* Hirsh v. Martindale-Hubbell, Inc., 674 F.2d 1343, 1349 n.19 (9th Cir.), *cert. denied*, 103 S. Ct. 305 (1982).

the vertical integration here.[11] The Fifth Circuit erred in failing to recognize and properly weigh these benefits.

IV. The Fifth Circuit Erred In Holding That The Hospital Had Sufficient Economic Power In The Market For The Alleged Tying Product To Restrain Competition In The Market For The Alleged Tied Product

a. As the court below recognized, 686 F.2d at 286, the vice of tying arrangements "is the wielding of monopolistic leverage; a seller exploits his dominant position in one market to expand his empire into the next." *Times-Picayune Publishing Co.* v. *United States*, 345 U.S. 594, 611 (1953). On the other hand, as Justice White explained in *Fortner Enterprises, Inc.* v. *United States Steel Corp.*, 394 U.S. 495 (1969) (*Fortner I*), "it is not all tying transactions in general, but only those where leverage in one market has been used to distort another which so far have been held illegal restraints of trade." *Id.* at 517 (White & Harlan, JJ., dissenting). The use of leverage is the economic factor which distinguishes a tying arrangement from an ex-

[11] This Court's decision applying the *per se* rule to a maximum price-fixing agreement among competing physicians in Arizona v. Maricopa County Medical Soc'y, 102 S. Ct. 2466 (1982), does not mandate application of the *per se* rule here. *Amicus'* argument is not, as in *Maricopa*, that the health care sector is "different" and thus that different rules should apply (although as explained in Section IV, *infra*, the court below improperly applied a "different" analysis in determining the geographic market). Rather the argument here is that, even if two products are involved, a tying arrangement exists only in form rather than effect. *See Broadcast Music, supra.* The agreement in question here achieves the type of integration missing in *Maricopa* by resulting in a product different from that produced by the parties individually. Because the parties to the agreement are not competitors, the anticompetitive potential of the arrangement, unlike that in *Maricopa*, does not justify facial invalidation. *See* 102 S. Ct. at 2475 n.18. Indeed, the only arguable rationale for applying the *per se* rule here is judicial efficiency, a justification that this Court specifically rejected in *Sylvania*, 433 U.S. at 50 n.16.

clusive dealing contract, and thus is the only justification for applying the *per se* rule to any tying arrangement. *See, e.g., Warner Management Consultants, Inc.* v. *Data General Corp.*, [1982-83] Trade Cas. (CCH) ¶ 65,062 (N.D. Ill. Aug. 16, 1982); Bowman, *Tying Arrangements and the Leverage Problem*, 67 Yale L.J. 19, 34 (1957) ("[a]nalytically, the per se rule demands a prior finding of leverage").

Leverage denotes the seller's creation of monopoly power in the tied product market through the use of power in the market for the tying product. The seller must be able to restrict output in the market for the tied product, and this cannot occur where, as here, the products are used in fixed proportions. *See, e.g.*, Bowman, *supra*, at 20, 23.[12] In this case, the products indeed are complements and used in fixed proportions, and what evidence there was suggested that output was not restricted. The Fifth Circuit specifically held that the exclusive contract did not increase the price for the tied product—anesthesia services—and thus output was not restricted. 686 F.2d at 291.

b. To exercise leverage and thus trigger application of the *per se* rule, a firm must have some degree of market power with respect to the tying product. *United States Steel Corp.* v. *Fortner Enterprises, Inc.*, 429 U.S. 610 (1977) (*Fortner II*), read together with *Fortner I, supra*, establish that a firm must have "appreciable economic power" in the market for the tying product before the *per se* rule is applicable. *Fortner II*, 429 U.S. at 611-12. In determining whether the seller has such power, the crucial question is "whether the seller has some advantage not shared by his competitors in the market for the tying product." *Id.* at 620. To prove "appreciable economic power" in the market for the tying product, a plaintiff must show that (1) the seller occupies a dominant position in the market, *Northern Pacific Railway Co.* v. *United States*, 356 U.S. 1 (1958); *Fortner I, supra;* (2) the tying product is

[12] *See also* note 5 *supra.*

sufficiently unique that it provides the seller with a significant competitive advantage over its competitors in the market for the tying product, *Fortner I, supra; Fortner II, supra;* or that (3) a substantial number of customers accepted the tie-in, and the seller's economic power is the only explanation for their doing so.[13] *Northern Pacific Railway Co., supra; Fortner II, supra. See generally United States* v. *Mercedes-Benz of North America, Inc.*, 517 F. Supp. 1369, 1384 (N.D. Cal. 1981).

The plaintiff appeared to rely on, and both lower courts analyzed, only the first indication of potential economic power—a dominant position in the market. There was no evidence regarding why any patients accepted the arrangement or that they objected to it;[14] and Dr. Hyde made no attempt to show that any of the Petitioner's services (much less its surgical facilities) were in any way unique or that the hospital had any competitive advantage over any other hospital on the east banks of Jefferson and Orleans Parishes. Indeed, the district court specifically found that the Petitioner had no such advantage, 513 F. Supp. at 540, and the Fifth Circuit did not address the issue.

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[13] The fact that many customers accept the two products together actually says little with respect to whether a firm has appreciable economic power because so many reasons can lead to acceptance. These include dealer or customer preference, low price, high quality, location, custom or any other factor upon which consumers base purchasing decisions. Thus, while market power is necessary to coerce purchasers to accept the package, the fact of acceptance is not inconsistent with little or no market power. *See generally* P. Areeda, *Antitrust Analysis: Problems, Text, Cases* ¶ 530, at 733 (1981).

[14] In this case, the reason that patients accepted the arrangement could be that patients do not choose the anesthesiologist, relying instead on the hospital, and that they are perfectly happy with the hospital's choice. *Cf.* Ungar v. Dunkin' Donuts of America, Inc., 531 F.2d 1211, 1218 (3d Cir.), *cert. denied*, 429 U.S. 923 (1976) ("[i]f the product in the second market would be accepted anyway, because of its own merit, then, of course, no leverage is involved").

c. The burden on the Respondent was then to show that the Petitioner had a dominant position in the market for surgical facilities or at least that it had sufficient power to engage in leverage. *See Fortner I*, 394 U.S. at 519 (White & Harlan, JJ., dissenting) ("[t]his evil simply does not exist if there is no power in the first market); *Warner Management Consultants, Inc., supra*, at 70,964 ("where there is no injury which reflects the presence of market power, the dangers associated with tying are absent and there is no justification for *per se* condemnation").

A firm has market power only if it can raise prices or decrease quality without losing significant numbers of customers. *See, e.g.*, Landes & Posner, *Market Power in Antitrust Cases*, 94 Harv. L. Rev. 937, 937 (1981). As the Fifth Circuit properly recognized, the relevant geographic market had to be delineated before the hospital's power could be assessed. 686 F.2d at 289. *See also United States* v. *Jerrold Electronics Corp.*, 187 F. Supp. 545 (E.D. Pa. 1960), *aff'd per curiam*, 365 U.S. 567 (1961). If patients residing in the purported geographic market readily travel to hospitals located elsewhere, a hospital in that market cannot exercise market power, and the area in question cannot be a relevant geographic market. *See generally* 2 P. Areeda & D. Turner, *Antitrust Law: An Analysis of Antitrust Principles and Their Application* § 5C, at 347-70 (1978).

d. The Fifth Circuit's analysis and conclusion regarding the relevant geographic market was a fundamental error in deciding this case. The court implicitly recognized, correctly, that the geographic market is "the area of effective competition" where "the seller operates, and to which the purchaser can turn for supplies." *Tampa Electric Co.*, 365 U.S. at 327. Nevertheless, the court ignored what little evidence there was on the issue (which was introduced by the Petitioner rather than by Dr. Hyde) and engaged in a unique and puzzling analysis which has no support in the record, in logic or in law.

A geographic market can be determined by examining the locations of firms with whom purchasers deal. Where a significant number of residents of a purported geographic market deal with firms located outside of that area and where residents of other areas deal with firms located in the purported market, the area in question cannot be a relevant geographic market. *See generally* Elzinga & Hogarty, *The Problem of Geographic Market Delineation Revisited: The Case of Coal*, 23 Antitrust Bull. 1 (1978). Residents of the purported market can and do purchase elsewhere, and firms outside the purported market clearly constrain the competitive behavior of firms inside, preventing them from exercising market power. If a firm (or all firms) within the purported market attempted to exercise market power by raising its prices, decreasing quality or tying the sale of an unwanted product or service, customers could and would deal elsewhere. *See generally* Werden, *The Use and Misuse of Shipments Data in Defining Geographic Markets*, 27 Antitrust Bull. 719 (1981).

The evidence showed that 70 percent of hospital patients residing on the east bank of Jefferson Parish used hospitals other than the Petitioner and that 30 percent of the Petitioner's admissions were patients residing in areas other than the east bank of Jefferson Parish. 513 F. Supp. at 540, 542; 686 F.2d at 289-90. Based on this evidence, the district court clearly was correct in holding that the relevant geographic market consisted of at least all east bank hospitals in Jefferson and Orleans Parishes, 513 F. Supp. at 542-43; and the Fifth Circuit clearly erred in holding that the geographic market consisted only of the east bank of Jefferson Parish. 686 F.2d at 289-91. The Fifth Circuit below in fact appeared to recognize implicitly that the geographic market actually is larger than the east bank of Jefferson Parish alone, conceding that a "traditional method of economic analysis," 686 F.2d at 290, would lead to the district court's conclusion; indeed, the court conceded that "[u]nder the analysis applied to a truly competitive market, [Dr. Hyde] has failed to prove an illegal tying arrangement." *Id.*

To circumvent the traditional manner of delineating geographic markets, the Fifth Circuit held that, because patients select the hospital closest to home, the market is the east bank of Jefferson Parish where the Petitioner is located. It reached this conclusion by assuming that patients favor public, non-profit hospitals such as the Petitioner because third-party payment insulates patients from price considerations and patients lack information regarding the quality of care provided at different hospitals. The court also relied on a Louisiana statute which directs the hospital to provide care in the east bank of Jefferson Parish, assuming that this somehow aided in geographic market delineation.

This analysis is riddled with unsupported assumptions and non sequiturs. First, the only evidence in the record on the issue of geographic market definition belies the Fifth Circuit's conclusion. As noted above, it showed significant passage of patients into and out of the purported market. For whatever reason this occurs, the fact that it does occur is totally inconsistent with the Fifth Circuit's conclusion. Second, even if third-party payment does render patients less sensitive to a hospital's charges than they otherwise would be, this means only that other variables, such as quality, are the focus of competition; it does not render traditional market analysis inapplicable. *See, e.g., Robinson* v. *Magovern*, 521 F. Supp. at 878-86 (substitution of quality for price as primary competitive variable; geographic market consisting of 16 counties and numerous hospitals).

Third, even if patients have less information about hospital quality than about the quality of other services they purchase, physicians have such information and can and do aid patients in hospital selection.[15] *See generally* P. Feldstein, *Health Care Economics* 84-90 (1979). Thus, just as the location of a supplier is a factor which customers weigh in determining with

[15] If patients are as uninformed as the court below surmised, then it is unlikely that they know which hospitals are public or non-profit, and thus it is unlikely that the hospital's status provides it with any competitive advantage.

whom to deal when purchasing any good or service, it may be a factor that patients consider in choosing a hospital. As in the case of other purchases, however, patients consider other variables as well, including quality, reputation and technological capacity. *See* American Hospital Association, *Comments to the Federal Trade Commission on Exclusive-Source Contractual Arrangements Between Hospitals and Physicians* (Dec. 21, 1982) (attached as Appendix A). The Fifth Circuit's conclusion, carried to its logical extreme, holds that every hospital literally is a monopoly. Practical reality in general, and the statistics in the record of this case in particular, show that this assumption is false.

Finally, the court below interpreted La. Rev. Stat. Ann. § 46:1055, which directs the hospital "[t]o represent the public interest in providing hospital and medical care in the district," as a mandate that the hospital "serve only the East Bank of Jefferson Parish." 686 F.2d at 291. But the statute, which patently *does not* restrict whom the hospital can serve, is wholly irrelevant to delineation of the geographic market. In no way does it constrain patients residing on the east bank of Jefferson Parish from choosing a hospital in Orleans Parish or patients from elsewhere from using the Petitioner, as the court below evidently assumed. The statistics show this conclusively. Geographic market definition is not a function of arbitrary, political boundaries but rather a function of economic variables, including where patients do obtain, and can obtain, the service in question.

In sum, the Fifth Circuit's geographic market definition was clearly erroneous. As that court itself properly recognized, destruction of that foundation destroys as well the court's conclusion: Under a "traditional method of economic analysis," Dr. Hyde "has failed to prove an illegal tying arrangement." *Id.* at 290. Without the improperly narrow and unique market definition constructed by the court below, there can be no basis for the Fifth Circuit's decision that the hospital has appreciable economic power.

CONCLUSION

The economic environment of health care is changing through public and private policy initiatives. The direction of these changes is such that increased application of antitrust law to health care may be anticipated. Those in the health field believe that well-reasoned application of the law is imperative to avoid needless and harmful disruption of critical patient care arrangements. To this end, and for the foregoing reasons, it is respectfully submitted that the judgment of the United States Court of Appeals for the Fifth Circuit should be reversed.

Respectfully submitted,

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APPENDIX A

December 21, 1982

Carol Thomas, Secretary
Federal Trade Commission
Washington, D.C. 20580

Dear Mr. Thomas

Through Mr. Arthur N. Lerner, Assistant Director of the FTC's Bureau of Competition, the American Hospital Association has been invited to comment on a matter pending before the Commission. Pending is a hospital request for an advisory opinion on an exclusive arrangement between the hospital and a physician group for the delivery of diagnostic radiology services to patients at the hospital.

The name of the hospital requesting the opinion has not been disclosed by the Commission's staff to AHA, but we have been assured that the hospital welcomes the submission of comments by the Association.

We understand the following: The hospital requesting the opinion is a general acute care facility in a medium-sized city. It is one of four hospitals operating in its area that offer a similar range of services, each of which has an exclusive contract with a different group of radiologists. The subject hospital has entered into a contract with a physician group that grants the group the exclusive right to provide diagnostic radiology services in the hospital. The group supervises the

radiologic technicians employed by the hospital and provides other administrative services to the radiology department. The physicians and the hospital bill patients independently for their services. The contract is for an initial term of three years and is renewable thereafter on an annual basis.

In response to Mr. Lerner's invitation, the American Hospital Association submits the enclosed comments concerning exclusive-source arrangements between hospitals and physicians. The AHA is the primary organization representing the nation's hospitals, with 6,300 institutional and 35,000 personal members.

Because the AHA does not have before it all of the particular facts and circumstances surrounding the subject arrangement, our comments do not draw a specific conclusion on the matter. Such facts as are known to us do not suggest an anticompetitive intent or outcome.

Our comments, moreover, do emphasize that there are compelling justifications for exclusive-source arrangements which are consistent with enhanced competition in the hospital and medical care marketplace. The AHA believes that the right to enter into such arrangements is important to hospitals and supports the right of a hospital to make such an arrangement in the interest of the best patient care.

If the Commission has any questions on these comments or would like any additional information, please contact me directly. The AHA very much appreciates the opportunity to present its views on this subject.

Sincerely

/s/ RICHARD L. EPSTEIN
Richard L. Epstein
Senior Vice President

mm
enc.
cc: J. Alexander McMahon
President, American Hospital Association
Arthur N. Lerner
Assistant Director, FTC Bureau of Competition

AMERICAN HOSPITAL ASSOCIATION'S COMMENTS TO THE FEDERAL TRADE COMMISSION ON EXCLUSIVE-SOURCE CONTRACTUAL ARRANGEMENTS BETWEEN HOSPITALS AND PHYSICIANS

General

During the past twenty years, hospitals increasingly have utilized exclusive arrangements with physician specialists to staff hospital departments, although the scope and nature of such arrangements vary widely. Medical specialties commonly offered through exclusive-source arrangements include anesthesiology, emergency care, pathology, and radiology. In addition, reflecting the growing specialization and increasing technological sophistication of medical care delivery, such hospital-based specialties as nuclear medicine, renal dialysis, cardiac catheterization, cardiac surgery, and major surgery, among others, have become frequent subjects of exclusive contracts between hospitals and physicians.

The American Hospital Association recognizes that medical care is being provided in hospitals by physicians under many forms of mutual agreement and does not advocate any specific manner of providing hospital or medical services as the best in any particular case. However, AHA supports the right of each hospital to make its own reasonable professional decisions in this area and recognizes that an exclusive-source arrangement between a hospital and a physician or group of physicians may serve important interests of the hospital and the community and confer significant benefits on patients, without adverse effect on (and often with enhancement of) competitive outcomes in the health care marketplace.

The Market For Hospital Care

To fully appreciate the potential benefits of exclusive source arrangements, it is important to recognize some of the unique aspects of the market for medical care and hospital services.

Foremost among these considerations is the relatively small degree of traditional price competition in the hospital marketplace confronting patients (and their physicians). Through either public (e.g., Medicare, Medicaid, and local assistance programs) or private health insurance, more than 90 percent of the American population is effectively insulated from most or all of the price of hospital care. This situation reflects conscious public policy in favor of health insurance protection implemented through entitlement programs, such as Medicare, and through tax subsidies for employers, employees and other individuals who receive or purchase health insurance benefits.

As a consequence of this situation, non-price factors have been the major parameters of competition among hospitals. Recent studies demonstrate that quality, reputation, and technological capacity are the prime determinants in the selection of a hospital by patients and by physicians, far outweighing other considerations such as geographic proximity.

At the same time, the absence of a price-competitive consumer marketplace does not signify a complete absence of pressures on hospitals and the public to control health care costs and improve hospital efficiency. Third-party payers (federal and state government, Blue Cross, and commercial health insurers) historically have used coverage policies and regulatory controls to promote more efficient use of high-volume ancillary services (e.g., radiology, pathology) and of high-cost, advanced-technology procedures. More recently, these payers have sought a complete restructuring of hospital payment systems in order to impose some measure of price competition on their "marketplace" for hospital services. For example, the Tax Equity and Fiscal Responsibility Act of 1982 created a system of Medicare cost limits for each hospital's total cost per discharge, a departure from Medicare's historical payment on the basis of cost per unit of service. This change is intended to provide a groundwork for a future Medicare payment system based on a prospectively-determined price per discharge, a direction in which other third-party payers also are moving.

Therefore, while consumers remain insulated from the cost consequences of their utilization decisions and from the dynamics of the changing hospital payment system, hospitals today must achieve more complete resource management, through control of volume and service utilization and through improvement of productivity, while maintaining the quality of services delivered. Obviously, because the hospital is not a practitioner of medicine, its relationships with physicians are of critical importance to a successful response.

Finally, it must be noted that the financial insulation of the consumer, in combination with the growing sophistication of medical care, has placed upon the hospital an increasingly broad legal obligation to ensure both the availability and the quality of needed hospital services. The expansion of this obligation has eliminated many of the legal distinctions between the hospital and the independent contractor-physician who practices within the institution that in the past shielded the hospital from the legal consequences of the physician's actions.

Potential Benefits of Exclusive Source Arrangements

Hospitals (and various courts presented with the issue) have identified numerous patient care and administrative benefits flowing from exclusive contractual arrangements. In general, a hospital seeks to ensure the constant availability of consistent, high quality, specialized administrative and professional services at a reasonable cost. This goal is particularly important with respect to those hospital-based ancillary services that indeed are most commonly the subject of exclusive arrangements—radiology, pathology, anesthesiology, and emergency room services.

These ancillary services are those that a hospital must—by virtue of licensure regulations, Medicare participation requirements, voluntary accreditation, and professional liability standards—guarantee as available to all patients using the hospital. Because patients typically do not select the physicians rendering these services, the hospital has a greater (and judicially-recognized) burden of responsibility in assuring the proper

quality and quantity of such services. By means of the exclusive contract, the hospital is better able to monitor the performance of a physician or physician group and, if dissatisfied, to terminate the arrangement on short notice and contract with others.

Other specific benefits identified with exclusive source arrangements include:

—Standardization of procedures within a hospital department in order to achieve reduced operating costs and to better assure consistency of outcome.

—Improved performance monitoring to assure that medical quality standards are being met. This result flows from standardization of procedures and the establishment of a single point of accountability for professional services in the department.

—More effective selection, maintenance, and utilization of equipment. Under an exclusive arrangement, the hospital and the contracting physicians have a mutual interest in the cost-effective use of expensive technology. This is not necessarily the case if the hospital merely serves as a "workshop" for the diverse interests of many independent practitioners.

—Relatedly, better scheduling in the use of facilities and support staff. Work is best done if the use of services is planned in advance. Such planning typically is a contractual obligation of the contracting physician or group and is simplified when coordinated through a sole source.

—Better work routines and teamwork, attributable to the fact that physicians, nurses, and technicians work together consistently. Also, supervision and training of departmental personnel is improved. The contracting physicians obtain the benefits of a division of labor, and have the ability and responsibility to pool knowledge and skills.

—Greater physician competence, due to increased specialization and the enhancement of skills through repetition of specialized procedures.

Quality standards in many areas of medical practice specify a minimum volume of procedures necessary to ensure continued proficiency.

—Contractual provision of a unified responsibility for the subject service, establishing a point of accountability for the hospital's administration and governing body. This contractual responsibility and accountability assists the hospital to discharge its ultimate responsibility, imposed by Medicare participation requirements, voluntary accreditation, and common law, for the composition and services of its medical staff.

—Higher commitment among the physicians to the efficiency and quality of the institution.

—An enhanced reputation for excellence, enabling the hospital to attract and retain highly-qualified medical staff members in all disciplines. This consideration is particularly important given the increasing willingness of courts to hold hospitals responsible for the competence of physicians granted staff privileges.

Effect on Competition and Legal Characterization

The typical hospital-physician exclusive privileges arrangement is largely analagous to an exclusive distributorship agreement in a commercial setting. The hospital simply decides with whom it will contract to provide services to the public. Thus, these arrangements typically involve vertical, rather than horizontal, lines of commerce, and are analyzed under the "rule of reason." Accordingly, the balancing of procompetitive benefits against anticompetitive effects is necessary to determine the reasonableness, and legal status, of any particular exclusive-source arrangement.

Courts presented with challenges to such an arrangement have inquired into the characteristics of the relevant local market, the

purpose motivating the arrangement, its duration, the manner in which the decision was made to utilize the arrangement, whether it sprang from anticompetitive or exclusionary interest, and the benefits to the hospital and its patients from the arrangement.

Despite the wide variety of market characteristics and contract terms, the courts have been virtually unanimous in upholding exclusive-source arrangements.* Failure to demonstrate injury to competition has been reflected in judicial findings that:

—individual hospitals lack a dominant position in the market;

—the arrangements have not been executed for the purpose of injuring competitors but rather for the purposes of assuring quality and enhancing efficiency;

—such restraints that may have resulted from the agreement have been reasonable in scope and duration; and

—on balance, competition among physicians and among hospitals has been promoted by the arrangements.

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* The one departure from the long line of decisions upholding exclusive arrangements, and apparently the only decision to apply *per se* analysis to such an arrangement, is the recent decision in *Hyde v. Jefferson Parish Hospital District No. 2*, 686 F.2d 286 (5th Cir. 1982), holding an exclusive contract for anesthesiology services to constitute a *per se* illegal tying arrangement. Because of the uniqueness of this decision, it is appropriate to point out certain erroneous departures in its reasoning.

—First, the tie-in doctrine is inapplicable where the arrangement *defines* the product the hospital sells. Ancillary services, such as anesthesiology, pathology, and radiology, are integral to the hospital's product: an episode of patient care. The U.S. Supreme Court has rejected the approach of defining a tie by looking for *potentially* severable items within a larger product. *Times-Picayune Publishing Co. v. United States*, 345 U.S. 594 (1953).

(Footnote continued on next page)

In this last respect, courts have paid careful attention to the fact that the quality of medical services and reputation of the hospital are important determinants of competition in medical care.

Accordingly, the courts have identified procompetitive benefits stemming from the hospital's enhanced ability to select qualified staff, improving the institution's ability to compete with others and raising the level of care in the community. A recent U.S. Court of Appeals decision described this effect on quality, and its implications for competition among physicians, as follows:

> "A closed department may enhance competition among hospitals in the marketplace by increasing the quality of care available. It may also serve to benefit competition among [physician] groups if the terms of the contract are not for unreasonable periods of time. Such a system would

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(Footnote continued from preceding page)

— Relatedly, it is not clear that patients or their physicians are appropriately viewed as the purchasers of these ancillary services. In view of the hospital's legal responsibility for assuring the quality and availability of such services for its patients, its potential liability for negligent rendition of those services, and its potential liability for negligently granting staff privileges, the hospital more appropriately may be characterized as the purchaser. [*See Dos Santos v. Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346 (7th Cir. 1982).] Under such circumstances, questions of tying are irrelevant.

— Finally, the *Hyde* court was in error in rejecting the conclusion of the district court that the relevant market was no smaller than a (limited) geographic area within which the hospital served approximately 30 percent of the total number of hospital patients (and, which area the hospital was required to serve by state law). In so doing, the Fifth Circuit erroneously ignored the variety of factors (and in particular, quality of care) which lead patients and physicians to choose a hospital, the large supply of hospital facilities in the area, and the extent to which physicians in the community have medical staff privileges at multiple facilities. Moreover, if the hospital rather than the patient is viewed as the purchaser of these services, the market clearly is larger than the Fifth Circuit determined.

> serve to encourage [physicians] to improve the quality of their services in order to obtain these contracts with hospitals." *Dos Santos v. Columbus-Cuneo-Cabrini Medical Center, supra.* (*See also Robinson v. Magovern,* 521 F. Supp. 842 (W.D. Pa. 1981).)

The AHA believes that improved patient care and resource management, as well as enhanced quality competition among hospitals, in fact result in the large majority of cases where hospitals have elected to utilize exclusive-source arrangements. Of course, a variety of factors, including peculiar local market characteristics, may serve to invalidate a particular contractual arrangement under rule of reason analysis. However, the AHA believes that the vertical nature of these agreements, combined with compelling management and professional quality justifications, weigh heavily in favor of their validity under the antitrust laws.

Application to Radiology Services

Diagnostic radiology services are an integral part of the inpatient operations of a hospital. Advances in technology have expanded the applications of diagnostic radiology in emergency services, pre-admission testing, and inpatient care. Further, patients and their attending physicians demand (and courts and regulators require) that hospitals ensure the quality and availability of this routinely necessary ancillary service. Accordingly, and as explained in detail above, a very significant number of hospitals have utilized the exclusive contractual arrangement as the means to ensure the necessary quality and availability of this service.**

The hospital, in addition, has a specific interest in the effective management of the radiology department—one that also can

** Although exact data on the prevalence of exclusive contractual arrangements is not available, a recent study conducted by the Health Care Financing Administration reports that, in 1977, 86.3 percent of hospital-based radiologists provided services under contractual relationships with one or more hospitals. (HCFA-NORC Survey of Physician Practice Costs and Incomes, 1977.)

be served directly by an exclusive contractual arrangement. Control of unnecessary x-ray utilization, as well as effective supervision of radiologic technicians, contributes to a reduction of professional liability risks and to the institution's ability to contain costs and to respond to pressures exerted upon it by third-party payers. Significantly, therefore, enhanced quality and management effectiveness in this critical support service improves the individual hospital's competitive position among the community and its medical practitioners. Moreover, the opportunity to obtain exclusive contractual rights from a hospital to provide radiologic services, in many parts of the country, will stimulate competition among radiologists in a broad, often multi-state, market.

Conclusion

Although the absence of detailed information concerning the particular fact situation before the Commission does not enable the AHA to reach a specific conclusion in this matter, such facts as are known to us suggest the existence of circumstances which would render the arrangement reasonable under federal antitrust laws. The AHA believes that there are compelling justifications to uphold the right of a hospital to enter into exclusive-source contracts when it finds that such arrangements are in the best overall interests of patient care.

[These comments submitted under cover letter dated December 21, 1982, in response to a request from the Commission.]

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No. 82-1031

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2
and EAST JEFFERSON HOSPITAL BOARD,
Petitioners,

v.

EDWIN G. HYDE,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF AMICUS CURIAE OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC. IN SUPPORT OF RESPONDENT

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QUESTION PRESENTED

Whether Section 1 of the Sherman Act is violated when a qualified physician specializing in anesthesiology is excluded from appointment to the medical staff of a hospital solely because of an arrangement between the hospital and a group of anesthesiologists which eliminates competition in the provision of anesthesiology services by giving such group the exclusive right to provide such services to patients in the hospital.

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On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

---

BRIEF AMICUS CURIAE OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC. IN SUPPORT OF RESPONDENT

The American Society of Anesthesiologists, Inc. ("ASA"), having obtained the written consent of all parties, respectfully submits this brief *amicus curiae* in support of the respondent, Edwin G. Hyde, M.D.

INTEREST OF AMICUS CURIAE

Founded in 1936, ASA is a national medical association composed of approximately 19,000 members, most of whom are physicians specializing in the practice of anesthesiology. Anesthesiology is a medical specialty involving the management of procedures for rendering a patient insensible to pain during surgical, obstetrical and certain other medical procedures and the support of life functions under the stress of anesthetic and surgical manipulation,

as well as a range of other clinical applications of physiological and pharmacological expertise.

The purpose of ASA is to develop and further the specialty of anesthesiology for the general elevation of the standards of medical practice. In furtherance of this purpose, ASA has adopted a policy against contractual and other arrangements which limit patients' access to anesthesiologists on grounds other than qualifications and competence. (See ASA Statement of Policy set forth in Appendix A hereto.) In ASA's view, such arrangements deny physicians and patients the benefits of competitive development of the specialty of anesthesiology. The limits of modern surgery are defined by the advances in anesthesiology as a science and the ability of anesthesiologists to support life functions and manage the stresses experienced by patients during surgery. The complexities and high risks incident to modern anesthesiological care necessitate maintenance of an environment conducive to improvement and innovation—essentially through competitive development of the specialty. This is the interest which prompts ASA to file this brief *amicus curiae* in support of respondent in this case.

SUMMARY OF ARGUMENT

The holding of the court of appeals below that the exclusive contract for the provision of anesthesiological care at petitioner hospital constitued a tying arrangement in *per se* violation of Section 1 of the Sherman Act was clearly correct under the standards laid down by this Court. There can be no doubt that two distinct "products" are involved in this case—the clinical practice of medicine by the anesthesiologist (the "tied product") and hospital facilities and support services (the "tying product"). In hospitals such as the one involved in this case (which are unlike clinics), anesthesiological care is not provided by the institution itself; nor is such care sold to the institution for "resale" to surgeons and patients. The service is provided by independent physicians

directly to patients, and where possible, anesthesiologists actively compete to be selected by patients or by surgeons and other physicians acting on behalf of patients.

It is not essential to the establishment of a tying violation that petitioner hospital possessed dominant power in the market in which it operates (*i.e.*, the market for hospital services), but only that it possessed sufficient economic leverage to be able to impose the tie-in upon an appreciable number of patients or surgeons who might otherwise have preferred the service of an excluded anesthesiologist. It is clear that petitioner hospital possessed the requisite economic leverage. Hospitals are not fungible (whether viewed in terms of location, quality of staff, technological capacity, specialization or non-profit status), and the choice of a hospital must often precede or supersede the choice of an anesthesiologist, thus effectively limiting the market for anesthesiology services to the chosen hospital itself.

The challenged arrangement had precisely the sort of pernicious effects which the *per se* tying rule was designed to prevent. It enabled petitioner hospital to evade the provider reimbursement limits of third party payers by diverting to hospital revenues reimbursement designated for physician services. It preempted the preferences of patients, surgeons and other physicians in selecting among qualified anesthesiologists, and restricted the level of anesthesia care available at the hospital. It monopolized the tied product market for anesthesiology services at the hospital. The hospital's delegation to a group of anesthesiologists—in which the hospital had a financial stake—of power to exclude their otherwise qualified competitors from an essential facility constituted a classic group boycott. In addition, the arrangement confined the practice of the contracting anesthesiologists to petitioner hospital, thus magnifying the anticompetitive effect and extending it to other hospitals.

The justifications offered for the exclusive contract present no legitimate basis for avoidance of *per se* illegality. The purported justifications are founded merely on the administrative convenience of the hospital rather than patient welfare or the competitive position of the hospital, and could as well be accomplished through the less restrictive alternative of appropriate, objective criteria for the granting and renewal of hospital staff privileges to qualified physicians, including a requirement of adherence to appropriate medical staff bylaws, rules and regulations designed to assure quality of care and adequate physician availability.

The government seeks to save the arrangement by having this Court reverse its longstanding and well-founded tying doctrine. The government's proposal that tying arrangements be presumed procompetitive until they result in monopolization of both the tying and tied product markets is supported neither in law nor logic, and flies in the face of Congressional intent. Nor should this Court retreat from its *per se* prohibition of tying arrangements. This is not the case of a single buyer choosing to enter into a requirements contract where the anticompetitive effects are limited to the foreclosure of competing suppliers from that one buyer's patronage. Here a supplier is using its economic leverage in one product market to coerce and exploit consumers in another product market. This arrangement, like virtually all tying arrangements, strikes at the very heart of our competitive economy—the weighing by consumers of the relative merits of competing products—and (as petitioners proclaim) it threatens to proliferate. It is therefore properly subjected to the *per se* rule rather than analyzed under the rule of reason, which would require courts to undertake functions properly left to the market.

ARGUMENT

I. APPLICATION OF THE PER SE RULE TO THE CLASSIC TYING ARRANGEMENT PRESENTED IN THIS CASE WAS FAITHFUL TO THE STANDARDS LAID DOWN BY THIS COURT.

The court of appeals condemned as a *per se* violation of Section 1 of the Sherman Act an arrangement whereby petitioner East Jefferson Hospital (hereinafter "the Hospital") granted the exclusive privilege to practice anesthesiology at its facilities to a particular group of anesthesiologists (Roux & Associates), thus tying use of the Hospital's facilities to patronage of the Hospital-designated anesthesiologists, and excluding respondent, Dr. Hyde, from the practice of anesthesiology at the Hospital notwithstanding the recommendation of the Hospital medical staff that he be granted staff privileges. This holding is fully in accord with the relevant standards laid down by this Court. Indeed, the facts presented in this case amply bear out the wisdom of this Court's long-standing adherence to the *per se* rule in tying cases.

A. The Clinical Medical Services Provided by Independent Anesthesiologists Are Generically Different From the Facilities and Support Services Provided by the Hospital.

At the outset, petitioners and allied *amici* attempt to short-circuit application of the tying doctrine in this case by suggesting that the clinical practice of medicine by an anesthesiologist is insufficiently distinct from such hospital services as the provision of operating rooms, blood, oxygen, drugs and nurses to warrant antitrust concern with protecting a patient's or surgeon's choice of a particular anesthesiologist, or an anesthesiologist's ability to compete on equal terms for the patronage of patients or of surgeons acting on behalf of patients. *See* Brief for the Petitioners (hereinafter "Hosp. Br.") at 41. It is noteworthy that neither the district court nor the court of appeals below deemed there to be any issue

as to the distinct nature of clinical medical services vis-a-vis hospital services.[1]

Although case law provides guidance for determining whether products or services are sufficiently distinct to invoke the tying doctrine, the issue turns largely on conventional wisdom reflective of the realities of the marketplace.[2] In ASA's view, a proper disposition of this case depends in the first instance upon an appreciation of the realities of the service provided by the anesthesiologist and the marketplace in which he or she operates.

1. ***The anesthesiologist practices a broad range of clinical medicine (not limited to the operating room), and is therefore more akin to the surgeon than to the radiologist or pathologist.***

As noted at the outset, anesthesiology is a specialized practice of medicine encompassing a broad range of clinical roles. Although the anesthesiologist may most often be called upon to care for patients undergoing surgery or for mothers in childbirth, the practice of anesthesiology extends beyond the operating room and the obstetrical suite.[3] Anesthesiology involves the "clinical" practice of medicine in that the anesthesiologist is called upon to diagnose, treat and care for the patient directly.

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[1] *See* 686 F.2d 286, 289 (5th Cir. 1982) ("The existence of a tying arrangement in this case has never been seriously disputed by appellees, since it is clear that . . . . we are dealing with two distinct services which a buyer should be able to obtain separately"). *See also* 513 F. Supp. 532, 540 (E.D. La. 1981).

[2] *See, e.g.*, R. Posner, ANTITRUST LAW: AN ECONOMIC PERSPECTIVE 181 (1976); Dolan & Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 Hous. L. Rev. 707, 757 (1981); *cf. Brown Shoe Co. v. United States*, 370 U.S. 294, 325 (1962).

[3] The responsibilities of the anesthesiologist also include the management of patients unconscious from whatever cause; the alleviation of various pain states and the establishment of nerve blocks; respiratory care and the treatment of chronic respiratory diseases; cardiac and respiratory resuscitation (including the management of drug poisoning cases); and intravenous fluid therapy. *See* V. Collins, PRINCIPLES OF ANESTHESIOLOGY 28 (1976); *cf.* LAWYERS MEDICAL CYCLOPEDIA § 25.8a (1976 Supp.).

This is true in the surgical suite no less than in other areas of the anesthesiologist's practice.

Apart from technical skills in administering anesthesia,[4] the anesthesiologist must function as an effective diagnostician, pharmacologist and physiologist.[5] During surgery, the anesthesiologist functions as

> ". . . the medical internist in the operating room. . . . [H]e advises the surgeon concerning physiologic dysfunction, pharmacological aspects and the treatment of medical complications that arise in the patient during the course of anesthesia and surgery. His province and sphere of activity is thus clearly defined. It is to care for the physiological functions of the patient, thereby permitting the surgeon to devote and concentrate his entire attention and skill to the reestablishment and correction of anatomical abnormalities. Thus, the surgeon's skills are directed more toward anatomy, while the anesthesiologist's

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[4] The technical aspects of administering anesthesia may be delegated to a qualified nurse anesthetist acting under the medical direction of an anesthesiologist or, if no anesthesiologist is available, another qualified physician. Nurse anesthetists cannot, however, either by training or by licensure, perform the medical role of anesthesiologists. *See* 513 F. Supp. at 540 (district court opinion below); O'Meara, *Liability of the Anesthesiologist in the Hospital Environment*, Med. Trial Tech. Q. 420, 422 (Spring 1979). Data from the 1981 American Hospital Association Census of Hospitals indicates that anesthesia for surgery is administered in 27.5% of cases by anesthesiologists practicing alone, in 61% of cases in a "team" mode with an anesthesiologist medically directing nurse anesthetists, and in 9.3% of cases by a team consisting of a physician other than an anesthesiologist (usually a surgeon) medically directing a nurse anesthetist.

[5] *See* Collins, *supra* at 27. All anesthetics in common usage today are lethal if administered in sufficient quantity. It is the anesthesiologist's responsibility to conduct a preoperative evaluation of the patient in order to determine the patient's physical and mental tolerance for anesthesia and to prescribe an appropriate mix of drugs and method of administration. Post-surgical responsibilities include the management of the patient's recovery from anesthesia and the treatment of pain and any complications from anesthesia. *See* O'Meara, *supra*, at 428-429, 431-435.

skills are directed more toward the physiology." Collins, *supra*, at 27-28.

Indeed, the administration of anesthesia (*e.g.*, to an aged patient with a heart condition) may entail greater risk than the surgical procedure itself, such that the patient's welfare depends primarily upon the medical judgment and skills of the anesthesiologist.[6]

It is popular, but fundamentally misleading, to class anesthesiologists with pathologists and radiologists under the rubric of "hospital-based" physicians. Unlike anesthesiologists, pathologists and radiologists typically do not practice in a direct physician-patient relationship, but rather essentially provide service to clinical physicians through the utilization of the hospital's laboratories and x-ray equipment, and frequently do so as employees of the hospital.[7] For lack of a clinical practice, radiologists and

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[6] *See United States v. The American Society of Anesthesiologists*, 473 F. Supp. 147, 152 (S.D.N.Y. 1979).

[7] While such services depend upon complex and sensitive equipment, the care of which must be closely supervised (*see* American College of Pathologoists Brief at 11), anesthesiology is much less equipment-intensive. *See* Transcript of May 15, 1980 (morning) at 54; Transcript of May 16, 1980 at 34 (some anesthesiologists furnish their own equipment, gases and drugs).

According to one recent study, approximately seventy-eight percent of pathologists and fifty-eight percent of radiologists have some sort of financial relationship with a hospital; the comparative figure for anesthesiologists was only twenty-seven percent. *See* American Medical Association, Center for Health Policy Research, Socioeconomic Monitoring System ("SMS") Report (February 1982). Even these figures do not indicate that exclusive arrangements of the type at issue in this case are widespread. In fact, the SMS Report indicates that over half of the pathologists and thirty percent of the radiologists (as well as eighty-seven percent of the psychiatrists) having financial relationships with hospitals were on salary. As discussed *infra*, a salary arrangement cannot be equated with an exclusive contract of the type presented in this case. While a breakdown of anesthesiologists' financial arrangements with hospitals is not contained in the SMS Report, testimony below indicated that contractual relationships between hospitals and anesthesiologists in New Orleans were not necessarily "exclusive" in nature. *See* Transcript of May 16, 1980 at 25-26.

pathologists need not be based at a hospital in order to compete to provide services there.[8] On the other hand, surgeons are "hospital-based", but it is well-recognized that the clinical nature of the surgeon's practice, like that of the anesthesiologist, clearly demarcates such practice from support services provided by the hospital.

The nature of his clinical practice makes the anesthesiologist most vulnerable to exclusive contracts. Unlike the pathologist and radiologist, who may compete outside the hospital, the anesthesiologist must have privileges at a hospital in order to compete for the patronage of patients there. But unlike the surgeon, the anesthesiologist is not able himself to admit a potential patient to another hospital if he is excluded from the hospital of the patient's choice. Only after the hospital has been chosen on the basis of other factors does the choice of an anesthesiologist generally arise, and that choice is necessarily confined to those anesthesiologists who are permitted to practice at the chosen hospital. So far as the anesthesiologist is concerned, the hospital at which he has privileges is the marketplace and the market is the group of patients admitted to the hospital.

2. ***The requisite distinction between anesthesiology and hospital services is apparent from the fact that anesthesiology is provided by an economic actor independent of the hospital.***

Petitioners seek to avoid the commercial, practical and legal realities which distinguish anesthesiology from hospital support services by asserting that the anesthesiologist's services are functionally complementary and pro-

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[8] *See* College of American Pathologists Brief at 11 n.7 ("In the case of pathologists, . . . competition is provided by independent laboratories whose services compete with those offered in hospitals"); Hosp. Br. at A-3 (Federal Trade Commission advisory opinion on exclusive radiology contract noting that the hospital in question "accepts radiological studies from other hospitals or from independent laboratories at the discretion of the attending physician").

vided in fixed ratio to surgical services, and not provided independently thereof. *See* Hosp. Br. at 40. Even accepting petitioners' assertion at face value,[9] it rests on the erroneous premise that patients and surgeons are indifferent as to who performs the anesthesiology service. As recognized by the court below, 686 F.2d at 291-292, the record in this case amply reflects the fact that anesthesiologists—and the respondent, Dr. Hyde, in particular—do compete for patronage of patients, or for referral by surgeons or other physicians on behalf of patients, on the basis of individual competence, quality and manner of care.[10] The patient has a vital independent interest in choosing a preferred array of practitioners, settings and services. The patient should not have to confront a "Hobson's choice" of foregoing either his chosen practitioner or else his chosen therapeutic setting where a preferred anesthesiologist is excluded from a hospital only because of an exclusive contract. *See* Dolan & Ralston, *supra*, at 721, 777. The Hospital's claims of "complete functional integration" cannot overcome the fact that the exclusive contract in this case restricted the alternatives

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[9] As discussed above, the assertion is not factually accurate. Anesthesiologists provide many medical services unrelated to surgical services. Moreover, the extent of anesthesia services required for surgery varies, and bears no fixed relation to the extent of surgical service that may be required. *See United States v. The American Society of Anesthesiologists, supra*, 473 F. Supp. at 152-154.

[10] *See, e.g.*, Transcript of May 15, 1980 (afternoon) at 17, 20-21, 33-35, 64-65; Transcript of May 16, 1980 at 25-31, 33-34, 47-48, 64-65, 69, 73-74, 87-88, 110, 116-117.

Inasmuch as anesthesiology services are for the most part covered by health insurance, any price competition among anesthesiologists is primarily directed toward insurers rather than patients. *See United States v. The American Society of Anesthesiologists, supra*. But it is clear that the hospital is not (at least in the absence of an employment relationship) the purchaser of anesthesia services or the customer of the anesthesiologist. Nor can the hospital itself practice medicine.

sought by patients and surgeons and restrained competition among anesthesiologists at the Hospital.[11]

Petitioners seek to escape this fact by contending that the exclusive contract accomplished "vertical integration" or the "functional equivalent" of an employment contract. Hosp. Br. at 43-44. But the Hospital is not a clinic which itself provides medical care as well as hospital services. Rather, the commercial reality is that use of the Hospital's facilities was tied to use of services provided by an economic entity distinct from the Hospital itself. Just as in *Fortner Enterprises, Inc. v. United States Steel Corp.* ("Fortner I"), 394 U.S. 495 (1969), this reality dictates that "separate products" are involved. There the Court reasoned that while credit is normally viewed as an inseparable part of the purchase price of an item, this is not so

> "where the credit is *provided by one corporation on condition that a product be purchased from a separate corporation*, and where the borrower contracts to obtain a large sum of money over and above that needed to pay the seller for the physical product pur-

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[11] *See International Business Machines Corp. v. United States*, 298 U.S. 131 (1936) (lease of tabulating machines tied to the purchase of punch cards used solely with the machines); *International Salt Co. v. United States*, 332 U.S. 392 (1947) (purchase of salt-dissolving or -dispensing machines tied to purchase of salt). Indeed, the fact that the anesthesiologist's services are performed only in a hospital makes the tie more—rather than less—pernicious, since the exclusionary effect upon anesthesiologists will therefore be greater than otherwise. *See* Baker, *The Supreme Court and the Per Se Tying Rule: Cutting the Gordian Knot*, 66 Va. L. Rev. 1235, 1270-1271 (1980). Nor can petitioners blur the distinction between anesthesiology services and hospital services simply by asserting that economic efficiencies accrue to the hospital by virtue of the exclusive contract. *See* Hosp. Br. at 39. Such assertion is relevant, if at all, only to the affirmative defense that the tying arrangement was essential to protect the Hospital's "good-will"—an issue distinct from "product separability." See p. 22, *infra*.

> chased.[12] Whatever the standards for determining exactly when a transaction involves only a 'single product', *we cannot see how an arrangement such as that present in this case could ever be said to involve only a single product.*" 394 U.S. at 507 (emphasis added; footnote omitted).[13]

It is irrelevant that the hospital might not have violated the antitrust laws had it employed anesthesiologists under a salaried arrangement. This Court disposed of such an argument in *Standard Oil Co. of California v. United States*, 337 U.S. 293 (1949).[14] Moreover, as shown below, the particular contractual arrangement involved here enabled the Hospital to exploit purchasers in a way it would not have been able to had the anesthesiologists been employed by it.

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[12] Similarly, in this case the functional relationship between surgical services and anesthesia does not correspond to the full extent of the tying arrangement, whereby use of the Hospital's facilities required that any and all anesthesiology service (not just that restricted to surgical anesthesia) be provided by the franchised group.

[13] While the lending entity was a wholly-owned subsidiary of the manufacturer and was established solely to facilitate the sale of the latter's product, the Court recognized that defendants cannot escape antitrust liability by foreswearing the separate corporate forms in which they in fact operated. *Id.* at 507 n.4. The lower courts have focused on the fact of separate billing (as was the case at bar) in determining that allegedly tied products or services were in fact separate. *See United States v. Jerrold Electronics Corp.*, 187 F. Supp. 545, 559 (E.D. Pa. 1960), *aff'd per curiam*, 365 U.S. 567 (1961); *Associated Press v. Taft-Ingalls Corp.*, 340 F.2d 753, 764 (6th Cir.), *cert. denied*, 382 U.S. 820 (1965).

[14] "Though it may be that such an alternative to the present system as buying out independent dealers and making them dependent employees of [defendant] would be a greater detriment to the public interest than perpetuation of the system, this is an issue, like the choice between greater efficiency and freer competition, that has not been submitted to our decision." *Id.* at 311-312.

B. The Hospital Necessarily Possessed the Requisite Degree of Power Over the Tying Product to Trigger Application of the Per Se Rule.

The district court below plainly misapplied this Court's standards for determining whether a defendant possesses sufficient economic power in respect of a tying product to trigger the *per se* prohibition of tying arrangements. This Court has "made unmistakenly clear that the economic power over the tying product can be sufficient even though the power falls far short dominance . . . ." *Fortner I*, *supra*, 394 U.S. at 502-503. All that is required in this regard is that the Hospital possess sufficient economic leverage to impose a tie-in upon "any appreciable number of [patients] within the market," whether they be "few or many, whether scattered throughout the market or part of some group within the market", even though "[its] power is not complete over them . . . ." *Id.* at 503. "[T]he crucial economic power may be inferred from the tying product's desirability to consumers," *United States v. Loew's, Inc.*, 371 U.S. 38, 45 (1962), or from "some advantage not shared by . . . competitors," whether a cost advantage or an advantage "differentiating" the tying product, *United States Steel Corp. v. Fortner Enterprises, Inc.* ("Fortner II"), 429 U.S. 610, 620 (1977), such that " 'there are some buyers who find [the] seller's product uniquely attractive . . .' " *Id.* at 621 n.14 (citation omitted). Importantly, it is unnecessary to determine the defendant's market share in either the tying or tied product market in order to establish a *per se* tying violation.[15]

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[15] *See United States v. Loew's*, *supra*, 371 U.S. at 45 n.4; *Northern Pacific Railway Co. v. United States*, 356 U.S. 1, 9 (1958), *quoting Standard Oil Co. of California v. United States*, *supra*, 337 U.S. at 305. It is noteworthy that even accepting the narrowest definition of the relevant market proffered by petitioners, *see* Hosp. Br. at 30, the Hospital's market share would exceed the 6.7% share which was found sufficient under a more lenient standard to condemn requirements contracts in *Standard Oil*.

After observing that seventy percent of the Hospital's patients were residents of the East Bank of Jefferson Parish, the district court found that "[i]t is likely that any individual will choose to go to the hospital closest to his home if it is possible to do so for the convenience of the family". 513 F. Supp. at 543. In view of the manifest market imperfection created by pervasive health insurance, the court of appeals was plainly correct in holding that this finding established sufficient economic power over the tying product to invoke the *per se* rule.[16]

Petitioners take issue with a second market imperfection cited by the court of appeals—"the lack of complete information regarding the quality of medical care offered" by different hospitals, 686 F.2d at 290—by arguing that "surgeons and other knowledgeable people almost always choose the hospital and anesthesiologists for surgery. . . ." Hosp. Br. at 33.[17] This begs the point. A hospital is generally chosen on the basis of many consid-

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[16] *See* Dolan & Ralston, *supra*, at 765-66 ("In a large city, it is unreasonable to group all hospitals into one geographic market, given the realities of intra-city transportation, community identification, and crime and safety issues"); Kissam, Webber, Bigus & Holzgraefe, *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 Calif. L. Rev. 595, 653 (1982) ("Hospitals . . . often may possess . . . market power because of a hospital's location . . . ."); *cf. Fortner I*, *supra*, 394 U.S. at 509 ("[a]lthough money is a fungible commodity . . . markets . . .are often imperfect . . . ."); *Fortner II*, *supra*, 429 U.S. at 620 (requisite power derives from lack of "completely competitive market").

[17] Similarly, the American Hospital Association asserts that while the location of a hospital is a factor weighed by patients, they "consider other variables as well, including quality, reputation and technological capacity." American Hospital Association Brief at 25-26. But these are simply varying factors which combine to form a patient's preference for a particular hospital, and it is such preferences which enable a hospital to retain some patients notwithstanding the exclusion of an anesthesiologist they might prefer. In this regard, there was testimony below that more difficult surgeries are performed at the Hospital and its anesthesia equipment is more complex. 513 F. Supp. at 538.

erations besides anesthesiology, with the result that the relevant market for anesthesiology services is effectively confined to those anesthesiologists permitted to practice at the chosen hospital. *See* p. 9, *supra*. The patient or surgeon will generally be constrained from switching to another hospital in order to obtain the services of a preferred anesthesiologist.

C. The Challenged Arrangement Had a Number of Plainly Anticompetitive Effects Which the Per Se Rule Is Designed to Prevent.

The fact that the arrangement at issue in this case involved the financial collusion of separate and independent providers of the tying and tied products has a significant bearing on its anticompetitive nature. It is recognized that one of the anticompetitive uses for tying arrangements "may be . . . to evade price control in the tying product through clandestine transfer of the profit to the tied product . . . ." *Fortner I*, *supra*, 394 U.S. at 513 (White, J., dissenting) (citation omitted). In the health care industry, cost containment efforts on the part of private and governmental third party payers has largely displaced traditional price competition as the mechanism for regulating the charges of health care providers.[18] According to one commentator well acquainted with the subject, the growth of arrangements of the type challenged in this case is linked to the cost containment efforts of third party payers, and the resultant incentive for hospitals to "divert a portion of the professional [physician] service fees for the hospital's administrative services." [19]

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[18] According to the American Hospital Association Brief (at 4a), third party payers recently "have sought a complete restructuring of hospital payment systems in order to impose some measure of price competition on their 'marketplace' for hospital services."

[19] Nord, *Antitrust Law and Exclusive Contracts: Obstacles to Patients' Benefits?*, Law, Med. & Health Care 66, 69 (April 1983). The author laments recent regulations issued under the Tax Equity and Fiscal Responsibility Act of 1982 which bar such diversion of

It is apparent that the Hospital employed a tying arrangement in order to avoid price controls on the tying (hospital) services by extracting added revenue from the tied (anesthesiology) services. Under the arrangement, although patients received a bill for anesthesia services from the Hospital which contained a separate charge for the medical service provided by the anesthesiologist, the Hospital kept 54 percent of all the anesthesia revenues for itself. This percentage was not correlated to Hospital costs (Transcript of May 15, 1980, morning, at 85-86), and generally resulted in profit to the Hospital. *See* 513 F. Supp. at 536.[20] As if to aid their case, petitioners point out that ultimate control over the level of the charges for anesthesiology services rested with the Hospital. Hosp. Br. at 3.[21] Thus, the Hospital used its lever-

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physician fees reimbursed under the federal Medicare program. According to the Department of Health & Human Services:

> "Some hospitals bill amounts for services of compensated physicians that exceed the compensation the physicians receive for the services. The inclusion in charges of amounts that exceed the physicians' compensation for the services *enables the hospital to realize a profit* from the services of compensated physicians. Our usual reasonable charge rules (under which carriers generally consider only the customary, prevailing and actual charges for services) have not been effective in preventing payment of *unreasonably high charges. Further, it is not reasonable to pay more for a service than the physician receives for furnishing it* . . . . Therefore, we believe it is necessary to recognize as reasonable only those charges that would return to the provider the cost of compensating the physician for the services being billed for." 48 F.R. 8914 (March 2, 1983) (emphasis added).

[20] Respondent resisted an identical arrangement because:

> ". . . it was a contract that indicated they were going to share in any revenues . . . . [T]o me, it indicated an attempt by the hospital to get into my particular private business and if they closed the anesthesia staff, why it wouldn't be too long before they wanted to close some other staffs." Transcript of May 16, 1980 at 75-76.

[21] In the absence of true vertical integration between the Hospital and the anesthesiologist group (a fact exploited by the Hospital),

age over the tying market not only to preempt patient/surgeon choice in the tied market, but also (by limiting the actual reimbursement of the anesthesiologists, but not the fees billed in their name) to overcharge health insurers who paid for the tied product.[22] The arrangement therefore fits the classic mold of a *per se* tying violation.[23]

Moreover, in return for entering into the financial arrangement, the anesthesiology group was awarded a complete monopoly over the tied product market for anesthesiology service.[24] As a result, in order to practice

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the arrangement appears to involve vertical price-fixing of a character more pernicious than the price-fixing condemned in *Arizona v. Maricopa County Medical Society*, 102 S.Ct. 2466 (1982).

[22] Thus, a crucial distinction between the arrangement at bar and a true employment relationship is that the arrangement hinged upon the receipt of third party reimbursement for physician billings, rather than physician salaries.

[23] *See, e.g., Atlantic Refining Co. v. Federal Trade Commission*, 381 U.S. 357 (1965) (arrangement between oil company and tire company whereby the former effectively conditioned the sale of its gasoline to dealers upon their purchase of tires from the latter, for which latter paid the oil company a commission, held equivalent to *per se* tying violation); *Federal Trade Commission v. Texaco, Inc.*, 393 U.S. 223 (1968) (similar). In rendering an advisory opinion on an exclusive radiology contract, the Federal Trade Commission declined to invoke the *per se* tying rule on the understanding that "the Hospital derives no direct exploitive financial benefit" from the contract. Hosp. Br. at A7-A8.

[24] *See* pp. 9, 14-15. The testimony of a former board member of the Hospital indicates that it was indeed to obtain "all of the rights and privileges of the monopoly . . . with the handsome income it was providing" which led Dr. Roux to tolerate "linkage or control with the hospital administration." Transcript of May 16, 1980 at 159. An analogous arrangement involving monopolization through contract was condemned in *Hecht v. Pro-Football, Inc.*, 570 F.2d 982, 992-993 & n.45 (D.C. Cir. 1977), *cert. denied*, 436 U.S. 956 (1978) ("when the restrictive covenant covers an essential facility . . . all possible competition is by definition excluded and the restraint is thus unreasonable *per se*—provided . . . that the facility can be shared practically"); *See also* Dolan & Ralston, *supra*, at 768-69 ("[O]btaining exclusive franchises [in hospitals is] plainly designed to exclude competitors. . . . [M]onopo-

at the hospital, any other anesthesiologist would have to be acceptable to (and likely have to buy into) the group, and be willing (as respondent was not) to submit to the financial arrangement. The Hospital's delegation to the group—in which the Hospital had a financial stake—of an arbitrary power to exclude the group's otherwise qualified competitors[25] from an essential facility constituted a classic group boycott.[26] By the same token, it cannot matter that the group secured its monopoly through a financial inducement rather than some form of coercion or control of the Hospital.[27]

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lization is an accurate characterization of 'what is really going on here.' ").

[25] The Hospital acknowledged that respondent would have been granted staff privileges had he been invited to join Roux & Associates. Transcript of May 15, 1980 (morning) at 18-19, 30-32.

[26] *See Associated Press v. United States*, 326 U.S. 1 (1945) (condemning news service bylaw permitting a member to block the membership application of a competitor); *American Medical Ass'n v. United States*, 317 U.S. 519 (1943) (conspiracy, *inter alia*, to deny hospital staff privileges to physicians pursuing disfavored financial mode of practice); *Fashion Originators' Guild of America, Inc. v. Federal Trade Commission*, 312 U.S. 457 (1941); *Klor's, Inc. v. Broadway-Hale Stores, Inc.*, 359 U.S. 207 (1959); *Silver v. New York Stock Exchange*, 373 U.S. 344, 361-367 (1963) (fair hearing must precede exclusion of competitors); *Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980), *cert. denied*, 450 U.S. 916 (1981) (third party payer requirement that psychologist services to be billed through a physician constituted boycott of independent psychologists); *Hecht v. Pro-Football, Inc., supra; Dolan & Ralston, supra* at 755 ("The application of the boycott theory to the hospital setting is manifest. *With franchises and staff size limits, the very purpose of the agreements is to exclude competitors*") (emphasis added); Kissam, Webber, Bigus & Holzgraefe, *supra* at 653 ("A system of exclusive privileges in each specialty would give each partnership the power to veto competitors who seek to join the hospital's staff. This situation is difficult to distinguish from the facts in *Associated Press v. United States*").

[27] While members of the group professed support of respondent's application to the Hospital in the belief that the contract was no longer exclusive after 1976, they were secure in the knowl-

The fact that other hospitals can and do emulate the practice cannot justify ignoring the effect of the tying arrangement on patients and anesthesiologists.[28] This Court prohibited *per se* an analogous arrangement in *Atlantic Refining Co. v. Federal Trade Commission*, *supra*, in part because of the "destructive effect . . . that would result from the widespread use of these contracts" to "sew up large markets." 381 U.S. at 371. In *Standard Oil Co. of California v. United States*, *supra*, 337 U.S. at 309, the Court similarly recognized that widespread use of requirements contracts would entrench established suppliers and hinder new competitors.[29]

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edge that the Hospital did not share such view, and their support of respondent did not extend to inviting him to join their group. *See* Transcript of May 15, 1980 (morning) 18-19, 30-32. Indeed, the group had an incentive to remain small enough to reap sufficient reward to offset the financial participation of the Hospital. Available medical care was necessarily diluted commensurately. Concern with adequate medical coverage apparently necessitated that the group agree to confine their practice to the Hospital, thus further magnifying the anticompetitive effect among anesthesiologists, and perhaps extending it to competing hospitals.

[28] *See* Hosp. Br. at 16-18. In this regard, petitioners misconstrue the Court's opinion in *Fortner II*, where the crucial fact was that defendant lacked any advantage with respect to the tying product (*i.e.*, credit, an essentially fungible commodity) which could not readily be matched by competitors through price competition. Hospitals, by contrast, are hardly fungible from the patient/surgeon's point of view, and are not generally chosen on the basis of price. See p. 14 & n.17, *supra*.

[29] According to one commentator, increased entry of physicians into the medical marketplace in recent years has created an administrative burden for hospitals, and the "easiest, least costly solution to this problem for hospitals will be more contracts with exclusive requirements . . . with specific physician groups." Nord, *supra*, at 68. The opinion in *Standard Oil* precludes any such justification for exclusive contracts:

> "If indeed, this [barriers to entry into the market] were a result of the system, it would seem unimportant that a short-run by-product of stability may have been greater efficiency and lower costs, for it is the theory of the antitrust laws that the long-run advantage of the community depends upon the

Nor does it aid petitioners to suggest that anesthesiologists might compete for exclusive contracts. It is not apparent how any such competition—which would involve only uncommitted groups and, as a practical matter, preclude solo practitioners at most hospitals—could be conducted on the basis of bona fide quality considerations.[30] Such "franchise competition" would amount simply to a bidding process, whereby the winner "purchased the . . . [hospital's] economic power and used it as a partial substitute for competitive merit in gaining a major share of the . . . [anesthesiology] market." *Federal Trade Commission v. Texaco, Inc.*, *supra*, 393 U.S. at 230. Indeed, the bidding would be for a monopoly of an *entire* relevant anesthesiology market.[31] Since such markets admit of feasible direct competition, however, there is no justification under the antitrust laws

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removal of restraints upon competitors." 337 U.S. at 309 (citations omitted).

[30] As the court of appeals recognized below, the capability and character of an anesthesiologist can most meaningfully be evaluated only once he is permitted to practice at the hospital. 686 F.2d at 291.

[31] *See* p. 17 & n.24, *supra*. The process would not be analogous to procompetitive price bidding for the patronage of a *customer*, but rather would be more akin to bribing the owner of a bottleneck facility to grant exclusive rather than equal access to it. *See Hecht v. Pro-Football, Inc.*, *supra*. In this light, the government's suggestion (Brief for the United States as Amicus Curiae [hereinafter "Gov. Br."] at 8, 12 n.15) that the arrangement in this case is somehow equivalent to the requirements contract (for the purchase of fuel by an electric utility) in *Tampa Electric Co. v. Nashville Coal Co.*, 365 U.S. 320 (1961), is plainly unfounded. The Hospital did not contract for *its* anesthesia requirements, but rather for the requirements of patients using the Hospital. By the same token, the requirements contract in *Tampa* did not result in the imposition of a tying arrangement upon third parties as did the arrangement in this case. The government's reasoning is plainly contradicted by this Court's opinion in the analogous case of *Atlantic Refining Co. v. Federal Trade Commission*, *supra*.

for their willful monopolization through franchising or otherwise.[32]

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[32] Petitioners overreach considerably by suggesting the existence of a strong consensus among lower courts that exclusive contracts presumptively pass antitrust muster. Hosp. Br. at 18-19 n.8. The court in *Dos Santos v. Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346 (7th Cir. 1982), endorsed the erroneous approach of district court below only in dictum based on a negligible record compiled on a motion for a preliminary injunction. By contrast, the court in *Konik v. Champlain Valley Physicians Hospital Medical Center*, 561 F. Supp. 700 (N.D.N.Y. 1983), followed the opinion of the court of appeals below in holding that an exclusive anesthesiology contract would constitute a *per se* tying violation upon proof that competition among anesthesiologists was thereby restrained, and absent proof of a legitimate, articulated medical reason for the contract which could not be accomplished in a less restrictive manner (as to which the court expressed doubt). The court also endorsed plaintiff's boycott theory, although ruling that summary judgment was premature.

Smith v. Northern Michigan Hospitals, Inc., 1983-1 Tr. Cas. (CCH) ¶ 65,289 (6th Cir. 1983), involved an exclusive contract for emergency room services; the court stressed that patients do not choose practitioners in this context, and that unlike this case, no tying arrangement was alleged or discernible. *Robinson v. Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981), *aff'd mem.*, 688 F.2d 824 (3rd Cir. 1982), *cert. denied*, No. 82-415 (U.S. Nov. 1, 1982), did not involve an exclusive contract; while the hospital imposed exacting standards, it was open to any physician to compete for staff privileges. *Capili v. Shott*, 620 F.2d 438 (4th Cir. 1980), reached only the interstate commerce issue under the antitrust laws. In *Harron v. United Hospital Center, Inc.*, 522 F.2d 1133 (4th Cir. 1975), *cert. denied*, 424 U.S. 916 (1976), the court provided no analysis whatsoever in dismissing a claim prior to the decision in *Goldfarb v. Virginia State Bar*, 421 U.S. 773 (1975). The state court cases cited by petitioners are either inapposite, *see Rumple v. Bloomington Hospital*, 422 N.E.2d 1309 (Ind. App. 1981) (relying on absence of exclusive contract); *Blank v. Palo Alto-Stanford Hospital Center*, 234 Cal. App. 2d 877, 44 Cal. Rptr. 572 (1965) (physicians exempt from state antitrust law), or unpersuasive upon analysis guided by more recent opinions of this Court. *See* pp. 22, 28, *infra*.

D. The Lack of Any Legitimate Justification for the Exclusive Contract Reinforces the Appropriateness of Per Se Treatment.

The court of appeals had the benefit of the decision in *Arizona v. Maricopa County Medical Society, supra,* where the Court firmly held that, with possible exceptions for bona fide quality of care or ethical considerations (which are not involved here), the health care profession is subject to *per se* antitrust rules no less than any other.[33] The court of appeals nevertheless considered—and rejected—petitioners' purported justifications for the challenged tying arrangement in the context of a narrow affirmative defense which this Court may have left open, *i.e.*, that the tying arrangement is essential to the adequate functioning of the tying product, and to protect the defendant's goodwill therein. As observed by the Court in *Standard Oil Co. v. United States, supra,* 337 U.S. at 306:

> "The justification most often advanced in . . . defense [of tying arrangements]—the protection of the good will of the manufacturer of the tying device—fails in the usual situation because *specification of the type and quality* of the product to be used in connection with the tying device is protection enough. . . ." (emphasis added).[34]

The less restrictive alternative test is thus part and parcel of a proper analysis, and quite clear-cut in application: defendant must show that appropriate quality standards—which admit of fair and open competition—

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[33] The court in *Konik v. Champlain Valley Physicians Hospital Medical Center, supra,* 561 F. Supp. at 712, likewise followed *Maricopa* in holding that *per se* rules apply to an exclusive anesthesiology contract.

[34] *See also Fortner I, supra,* 394 U.S. at 503 ("tying arrangements generally serve no legitimate business purpose that cannot be achieved in some less restrictive way"); *Northern Pacific Railway Co. v. United States, supra,* 356 U.S. at 6 & n.5; *cf. Atlantic Refining Co. v. Federal Trade Commission, supra,* 381 U.S. at 371 (distributional efficiencies do not justify tying arrangement).

are infeasible to meet any significant and legitimate concerns allegedly served by the tying arrangement.

Petitioners fail to meet their burden in this regard for two broad reasons. First, petitioners' proffered justifications—to the extent they are plausible at all—rest on the premise that competition should be displaced in the interest of perceived administrative efficiencies which do not relate significantly either to patient welfare or the good will or competitive position of the Hospital. Such justifications thus constitute "nothing less than a frontal assault on the basic policy of the Sherman Act." *National Society of Professional Engineers v. United States*, 435 U.S. 679, 695 (1978).[35] Just as importantly, all of petitioners' purported concerns could be met through the use of appropriate, objective criteria for the granting and renewal of hospital staff privileges to anesthesiologists, including a requirement of adherence to appropriate bylaws, rules and regulations of the organized medical staff and anesthesia department designed to assure quality of care and adequate coverage.[36] Indeed, the principal

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[35] *See also* Dolan & Ralston, *supra*, at 748 (such justifications imply "a wholesale repeal of the antitrust laws for the health care industry . . . since all anticompetitive practices in the health care industry invariably are grounded on such notions").

[36] The latter concept underlies a document entitled "The Organization of an Anesthsia Department", adopted by the ASA House of Delegates and attached hereto as Appendix B, which details how an open anesthesiology staff can be operated consistently with continuous, high quality patient care. *See also* Dolan & Ralston, *supra*, at 761 (control of staff privileges is sufficient to achieve hospital's administrative and patient care justifications for exclusive contracts.)

Petitioners' assertion that "either 'open' or 'closed' departments restrict the choice of anesthesiologists to those admitted to practice in the hospital" (Hosp. Br. at 34-35, 44) is plainly misplaced. Admission to an open staff depends upon an applicant's qualifications, willingness and ability to meet objective standards, and thus, unlike an exclusive arrangement, permits fair competition on the basis of individual merit. Indeed, even an employment relationship admits of some competition among individuals for a position.

distinction between an open anesthesia staff and an exclusive franchise in this regard is simply that the latter is comprised of a smaller number of anesthesiologists organized into a non-competitive group.[37]

Both petitioners and the government place special emphasis on the proposition that the exclusive contract promoted the efficient use of nurse anesthetists.[38] But nurse anesthetists are effectively utilized in open departments as well.[39] Moreover, any savings through the use of nurse anesthetists were not passed on to patients or their insurers. *See* Hosp. Br. at 3, 25-26. Finally, while petitioners and the government urge protection of com-

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[37] *See* American Hospital Association Brief at 7, 18-19 ("'the fewer the physicians, the easier it is for a hospital to control quality'"); Nord, *supra*, at 67 (advantage of exclusive contract is the provision of coverage "by a smaller number of anesthesiologists than would exist if the hospital had an open anesthesiology department").

In strongly commending open anesthesia staffs as most conducive to competition and optimal patient care, ASA need not contend that hospitals are necessarily "utilities." The issue presented here is the exclusion of one, eminently qualified anesthesiologist from a hospital at which four anesthesiologists covered twelve operating rooms simultaneously (513 F. Supp. at 538). *Cf. Associated Press v. United States*, *supra*, 326 U.S. at 19. While the utility approach to hospital staff privileges has in fact been employed by state courts, *see* Slawkowski, *Do the Courts Understand the Realities of Hospital Practices?*, 22 St. Louis U. L. Rev. 452, 461 (1978), the court of appeals opinion below "[did] not test the limits of access to staff privileges." 686 F.2d at 295. Legitimate concern with overcrowding is not at issue here and in any event could be dealt with by raising the standards and encouraging individual competition for the award of staff privileges. *See Robinson v. Magovern*, *supra*; *cf. United States v. Terminal R.R. Ass'n of St. Louis*, 224 U.S. 383, 411 (1912) (bottleneck facilities must be fairly shared).

[38] Hosp. Br. at 24-28; Brief for the United States on Petition for Writ of Certiorari at 10; Gov. Br. at 15 n.19.

[39] *See* Hosp. Br. at 26 n.14; Transcript of May 15, 1980 (morning) at 67-68; Transcript of May 16, 1980 at 95.

petition by non-physician health care providers, Gov. Br. at 15 n. 19; Hosp. Br. at 27, the reality of this case is that fully-qualified anesthesiologists—not nurse anesthetists—are being arbitrarily precluded from practice at the Hospital.[40]

Petitioners also make reference to a standard litany of supposed generic justifications for exclusive contracts which originated in non-antitrust state cases.[41] *See* Hosp. Br. at 23-24. Such justifications are not established in the record before the Court in this case. Chief among them is the implausible claim that an exclusive contract—which *limits* the number of available anesthesiologists—facilitates emergency coverage and flexible scheduling.[42] Dr. Roux testified that he deemed himself professionally bound to be available for coverage regardless

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[40] In point of fact, anesthesiologists do not compete with nurse anesthetists. See p. 7 n.4, *supra; United States v. The American Society of Anesthesiologists, supra,* 473 F. Supp. at 160 n.22. In any event, the antitrust laws protect competition, not competitors. *Brunswick Corp. v. Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488 (1977). The suggestion that anesthesiologists are justifiably excluded from the hospital because their services are more costly than that of the nurse anesthetists ignores the teaching of *Arizona v. Maricopa County Medical Society, supra,* where this Court condemned maximum price-fixing because it provided "the same economic rewards to all practitioners regardless of their skill, their experience, their training, or their willingness to employ innovative and difficult procedures in individual cases . . . . [and] also may discourage entry into the market and may deter experimentation and new developments by individual entrepreneurs." 102 S. Ct. at 2475.

[41] *See, e.g., Blank v. Palo Alto-Stanford Hospital Center, supra*; *Adler v. Montefiore Hospital Ass'n of W. Pennsylvania*, 53 Pa. 60, 311 A.2d 634 (1973), *cert. denied*, 414 U.S. 1131 (1974).

[42] It is likewise nonsensical to suggest that an exclusive anesthesiology contract enhances the reputation for excellence of the anesthesiology department, "thus enabling [the hospital] to attract top flight physicians." American Hospital Association Brief at 8-9. It has been observed that surgeons have a strong interest in maximizing the size of a hospital's anesthesiology department. Dolan & Ralston, *supra*, at 715.

of the exclusive contract. 686 F.2d at 288 n.2.[43] Moreover, such professional obligations can be and frequently are incorporated into medical staff bylaws, rules and regulations which physicians are bound to observe as a condition of maintaining staff privileges.

Similarly, the suggestion that an exclusive contract may be justified because, by limiting the number of anesthesiologists, it may facilitate closer monitoring of anesthesiologists, greater repetition and standardization of procedures,[44] easier maintenance of equipment,[45] and reduced exposure to malpractice liability,[46] is suspect; the exclusive contract did not reduce the number of practitioners administering anesthesia at the Hospital, only the number of anesthesiologists.[47] Moreover, each of these purposes appears to have little to do with enhancing competition among either anesthesiologists or hospitals (*e.g.*, "standardized procedures" would displace innovation), and

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[43] Dr. Roux similarly disagreed that having more than one group at the hospital would be chaotic or necessarily detract from the quality of care. *See* Transcript of May 15, 1980 (afternoon) at 12-13, 19, 33-34; *see also* Transcript of May 16, 1980 at 34, 87-88.

[44] There is no reason to expect that an already full-time anesthesiologist would repeat procedures more often under an exclusive contract, as opposed to delegating more procedures to nurse anesthetists.

[45] Anesthesiology, by comparison with pathology and radiology, is not equipment-intensive. *See* p. 8 n.7, *supra*.

[46] "[A]bsent hospital representations as to the quality or laxity in ensuring minimal quality, legal liability of independent contractors is unlikely to be imputed to the hospital." Dolan & Ralston, *supra*, at 761 (citation omitted). *See also* Kissam, Webber, Bigus & Holzgraefe, *supra*, at 607-609; Slawkowski, *supra*. The Hospital's legal responsibility to monitor the nurse anesthetists it employed was certainly greater than for independent staff physicians.

[47] It is noteworthy also that the Hospital reserved no control over the growth of the franchised group of anesthesiologists. *See* Transcript of May 15, 1980 (morning) at 30-32.

could in any event be accomplished through rigorous standards and review in granting hospital privileges, backed by appropriate bylaws, rules and regulations.[48]

II. THE GOVERNMENT'S PROPOSAL FOR RADICAL SURGERY ON THE TYING DOCTRINE IS ILL-CONCEIVED AND SHOULD BE REJECTED.

The government focuses primarily on challenging this Court's well-established tying doctrine rather than on the facts of this case.[49] The government would indeed have this Court take "an abrupt . . . [and] radical departure from current law," Gov. Br. at 7, for which the government offers virtually no authority. The government asserts first that a tying arrangement "cannot have an anticompetitive effect" unless the arrangement results in the elimination of "enough" existing rivals in the tied product market to control price (*i.e.*, a monopoly). Gov. Br. at 25.[50] In fact, however, the tying arrangement in this case did result in the monopolization of the tied product market for anesthesiology services. *See* p. 17, *supra*.

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[48] Thus, additional justifications offered for the exclusive contract, such as the willingness of anesthesiologists to commit themselves to a particular hospital, to undertake supervisory and training responsibilities there, or to "operate as a team" were in fact incorporated into the consideration of individual applications for staff privileges in *Robinson v. Magovern*, *supra*.

[49] The Federal Trade Commission does not join in this effort. Gov. Br. at 7 n.9.

[50] The government's assertion is predicated merely on the broad presumption that tying arrangements involve distribution efficiencies and that the competitive alternatives eliminated may not be as efficient. *Id.* at 22, 25 n.29. However, this case amply supports the Court's long recognition that because any foreclosure in the tied market is rooted in *economic leverage* in the tying market used to effect a *mandatory* joint purchase, *despite* the less restrictive alternatives open to the seller, it can justifiably be presumed to "crippl[e] other companies that are equally, if not more, efficient . . ." *Fortner I*, *supra*, 394 U.S. at 509. *See also*,

The government then asserts that a tying arrangement still cannot be "anticompetitive" unless the supplier also has power to exclude the entry of competitors into the tying product market (*i.e.*, a second monopoly), since he cannot otherwise necessarily, indefinitely and fully exploit consumers in that market. Gov. Br. at 25-26. This case bears out this Court's practical wisdom that even though a supplier falls short of market dominance, he may possess sufficient leverage through market imperfections to preempt choice and extract overcharges to an appreciable extent through a tying arrangement, and that unless strictly dealt with, such arrangements threaten to proliferate and magnify in effect.

Finally, the government advocates that tying arrangements be evaluated under a rule of reason rather than a *per se* standard. In this regard, the government suggests that "[s]ince the anticompetitive potential of tie-ins and exclusive dealing [*i.e.*, requirements] contracts is basically identical, both arrangements should be judged by the same criteria." Gov. Br. at 20. However, buyers may freely choose in their own economic interest to enter into a requirements contract, and any anticompetitive effects are

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e.g., id. at 503; *Northern Pacific Railway Co. v. United States, supra,* 356 U.S. at 6.

At bottom, the government's theory reflects a truncated concept of the role of the antitrust laws, which would remain dormant so long as competition had not been virtually eliminated from the market. However, a greater number of unimpeded competitors fosters more robust competition, greater alternatives, and greater innovation. *See, e.g., Northern Pacific Railway Co. v. United States, supra,* 356 U.S. at 4 (in enacting the Sherman Act, Congress established "free and unfettered competition as the rule of trade"); L. Sullivan, HANDBOOK OF THE LAW OF ANTITRUST 447-448 (1977). Indeed, Congress enacted Section 3 of the Clayton Act—specifically prohibiting tying arrangements—to arrest restraints of trade in their incipiency. *See, e.g., International Salt Co. v. United States, supra,* 332 U.S. at 396. The standards under the Sherman Act and Clayton Act appear to be identical in this regard. *See Fortner I, supra,* 394 U.S. at 521 (Fortas, J., dissenting); *Moore v. Jas. H. Matthews & Co.,* 550 F.2d 1207, 1214 (9th Cir. 1977).

limited to the resultant foreclosure of the supplier's competitors from such buyers' patronage. The distinguishing feature of tying arrangements is the use of power in one market to create a double-barreled anticompetitive effect in another market. Tying arrangements not only foreclose competitors from fair access to the second market, but also coerce and exploit customers in that market as well.[51]

In sum, this Court has appropriately recognized the crucial distinction between the situation where a buyer *chooses* to enter into a requirements contract and the situation where the buyer's judgment is preempted by a tying arrangement imposed through the exercise of a seller's economic leverage. It is the very function of the market to make such economic judgments, and it is the salutary purpose of the *per se* prohibition on tying arrangements to protect the functioning of the market in this respect, in lieu of displacing it with the judgment of a court acting under the guise of a rule of reason analysis. Tying arrangements—unlike requirements contracts—inevitably and unnecessarily restrain competition by distorting purchaser decisions.

ASA submits that this is hardly the case in which to reverse thirty-five years of consistent Supreme Court precedent applying the *per se* rule in tying cases. In the circumstances of this case, which involves the administration of lethal drugs to human beings under carefully con-

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[51] *See United States v. Loew's Inc., supra,* 371 U.S. at 44-45; *Northern Pacific Railway Co. v. United States, supra,* 356 U.S. at 6, 10; *Standard Oil Co. of California v. United States, supra,* 337 U.S. at 306-307 (because "[r]equirements contracts . . . may well be of economic advantage to buyers as well as to sellers . . . . the coverage by such contracts of a substantial amount of business affords a weaker basis for the inference that competition may be lessened than would similar coverage by tying clauses . . . ."); *Federal Trade Commission v. Brown Shoe Co., Inc.,* 384 U.S. 316, 321 (1966) ("the central policy of both § 1 of the Sherman Act and § 3 of the Clayton Act [is] against contracts which take away freedom of purchasers to buy in an open market").

trolled conditions, the elimination of competition through a classic tying arrangement is not simply a matter of dollars and cents. It can adversely affect the quality of medical care. ASA believes that in this setting it is particularly important that competition be allowed to reward superior performance and innovation, while exposing the indifference to quality that may too often be the hallmark of a monopoly. By advocating approval of tying arrangements in these circumstances, the government is advocating the abandonment of competition in an important segment of the medical care marketplace. If this is what the government wants, its arguments are properly addressed to Congress, not to this Court. See Arizona v. Maricopa County Medical Society, supra, 102 S. Ct. at 2478-2479.

CONCLUSION

For the foregoing reasons, this Court should affirm the judgment of the court of appeals below and hold that the exclusive contract in this case constituted a *per se* violation of the Sherman Act.

Respectfully submitted,

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July 7, 1983

APPENDIX A

THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC.

STATEMENT OF POLICY

(Amended by House of Delegates on October 16, 1980)

The American Society of Anesthesiologists is a non-profit association of reputable doctors of medicine engaged in the practice of or otherwise especially interested in anesthesiology.

As provided in the Bylaws, the Society holds to the following purposes:

To advance the science and art of anesthesiology and

To stimulate interest and promote progress in the scientific, cultural and economic aspects of the speciality of anesthesiology.

It is the official policy of The American Society of Anesthesiologists, Inc. that an anesthesiologist is free to choose whatever arrangement he prefers for compensation of his professional services. The Society does not consider the compensation arrangement so chosen to be a matter of professional ethics. In addition, an anesthesiologist's compensation arrangements shall not affect his or her eligibility to attain or retain membership in this Society or any of its component societies.

Since anesthesiology has encountered problems individual to it relating to the quality and standards of patient care, which experience has shown are due in part to the form of compensation arrangements entered into by anesthesiologists, the Society believes that its members should be specifically cognizant of the following principles advocated by it:

I The practice of anesthesiology by a member of the Society is the practice of medicine and is not an institutional "service".

II The sole source of the income of a member of this Society from professional practice should be the service rendered to the patient by the member or under the member's direct, personal and continuous supervision, and for which the patient or the patient's agent is billed directly.

III A member of this Society should not enter into or remain in any relationship whereby the member's professional services are offered for a fee. This should not be construed to preclude the organization of physicians into groups in the form of professional corporations or associations having the characteristics of corporations, where such organizations are specifically permitted by law, and where ownership and management are—and are required either by law or contract to remain—exclusively in the hands of physicians. Further, a stipend may properly be accepted for teaching or administrative duties, or for service to non-pay patients, if the number of such patients is great enough to require it.

IV Exploitation of anesthesiologists by other anesthesiologists is improper. For example, in group practice, after a short trial period to determine acceptability, each anesthesiologist should generally receive income that is relatively proportionate to the service rendered for the group.

V Exploitation of physicians-in-training is improper. When an anesthesiologist supervises the administration of anesthesia by a physician-in-training to private patients or renders some lesser portion of the anesthetic care of such patient, fees charged should be commensurate with the services provided by the directing anesthesiologist.

VI Contracts, arrangements, or agreements between a hospital and an anesthesiologist or a group of anesthesiologists, or between anesthesiolgists themselves, whether establishing an exclusive or other form of practice arrangement, should not restrict a patient's access to quality medical care or limit the optimal utilization of hospital facilities, by preventing qualified physicians who might otherwise desire to, or be acceptable for, practice in the institution from securing staff appointments in and practicing anesthesia. Where a hospital's other clinical departments have open medical staffs, an otherwise qualified anesthesiologist, willing to share in the responsibilities for providing necessary anesthesia service, should not have to become part of any specific group or have any specific financial relationship with the hospital or with another physician as a condition to becoming a member of the staff of the hospital, or as a condition to participate in the provision of anesthesia care, free of arbitrary restraint.

This Statement of Policy contains principles formally adopted by and strongly advocated by this Society. Neither acceptance of nor adherence to this Statement of Policy is a condition of any privilege of membership in the Society and the adoption and publication of this Statement of Policy is not intended to interfere with any member's exercise of independent judgment. Each member of the Society, however, is urged to consider the principles stated herein as they apply to the member's own medical practice.

APPENDIX B

THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC.

THE ORGANIZATION OF AN ANESTHESIA DEPARTMENT

(Approved by House of Delegates on October 26, 1982)

Experience has shown that anesthesiology has encountered problems individual to it relating to the quality and standards of patient care which are due in part to practice arrangements between hospitals and anesthesiologists and between anesthesiologists themselves. In response to these problems, The American Society of Anesthesiologists has adopted a *Statement of Policy* which contains principles which the Society urges its members to consider in structuring their own individual medical practices.*

Provision of quality anesthesia care for the patient requires that individual medical practices within the context of the individual hospital be organized for administrative purposes into a functioning entity, or department, which is managed and operated in a manner which will facilitate the patient's access to quality anesthesia care and promote the efficient fulfillment of the responsibilities of individual physicians and the hospital's administration to the patient and the community. Because of the diversity of local conditions, no single framework for the organization and management of a department of anesthesia which is suited to all situations can be recommended. However, the organization of the department of anesthesia should be consistent with the organization of

* It is the official policy of the Society that an anesthesiologist is free to choose whatever arrangement he prefers for compensation of his professional services. The Society does not consider the compensation arrangement so chosen to be a matter of professional ethics.

the hospital's other clinical departments and should assure the availability of quality anesthesia care where and when needed in the hospital. In addition, the following suggestions should be considered in addressing the practical problems of organizing and managing an anesthesia department which has quality patient care as its primary goal.

I. PHYSICIAN RESPONSIBILITIES FOR MEDICAL CARE

Since the quality of care in anesthesia depends in large measure upon the role of the physician in rendering such care, the proper definition of the responsibilities of individual physicians in the provision of medical care is the starting point in the organization of an anesthesia department. Such definition should take into account the following principles:

A. Anesthesia care is the practice of medicine. An anesthesiologist must be personally responsible to each patient for the provision of anesthesia care.

B. The anesthesiologist's responsibilities to the patient should include responsibility for preanesthetic evaluation and care, medical management of the anesthetic procedure and of the patient during surgery, post-anesthetic evaluation and care, and medical direction of any nonphysician who assists in providing anesthesia care to the patient. The anesthesiologist should fulfill his responsibilities to the patient in accordance with the ASA *Guidelines to the Ethical Practice of Anesthesiology* and *Guidelines for Patient Care in Anesthesiology.*

C. An anesthesiologist exercises the same independent medical judgment on behalf of the patient as is exercised by other physicians. When rendering medical care to a particular patient, an anesthesi-

ologist is not working for, or as the agent of, the hospital, nor is the anesthesiologist discharging an institutional responsibility. Accordingly, the hospital should not be responsible for the proper performance of this care, and should not direct or control the manner in which it is performed.

D. As a member of the hospital medical staff, an anesthesiologist is subject to and must observe, as well as be accorded the benefits of, the medical staff bylaws, rules and regulations generally applicable to all physicians granted privileges in the hospital. Additional rights and responsibilities may arise from rules and regulations specifically applicable to physicians in the department of anesthesia.

E. An anesthesiologist with full staff privileges must share on a fair and equitable basis in the responsibility for assuring 24-hour a day, 7-day a week availability of anesthesia care.

II. MEDICO-ADMINISTRATIVE ORGANIZATION AND RESPONSIBILITES

The department of anesthesia has the responsibility to promote and ensure patient access to quality care in anesthesia and the optimal utilization of hospital facilities. To fulfill this responsibility, it is necessary, but not in itself sufficient, to grant staff privileges to all qualified physicians who desire to practice anesthesia in the hospital and who are committed to fulfilling individual physician responsibilities for medical care. Additionally, the anesthesia department must develop a practicable system which will assure the constant personal availability of a member of the department. The department must also monitor and enforce adherence to standards of care, the medical staff bylaws and the rules and regula-

tions particularly applicable to the anesthesia staff. The discharge of these administrative responsibilities should be guided by the following principles:

A. The assumption and performance of medico-administrative responsibilities, though for the ultimate benefit of patients, are undertaken on behalf of, and as the agent for, the hospital. The fact that a physician has medico-administrative responsibilities should not affect his, or any other physician's, individual responsibilities to patients or his rights under the medical staff bylaws.

B. All members of the staff should share in the discharge of medico-administrative responsibilities to the extent necessary or appropriate.

C. Administration of the anesthesia department should be directed by a qualified anesthesiologist member of the medical staff. The director should be elected or appointed in the same manner as the directors of the other clinical departments in the hospital.

D. The director of the anesthesia department should be responsible for the following medico-administrative functions in a manner similar to directors of other clinical departments.

   1. Recommending clinical privileges for all individuals with primary anesthesia responsibilities. Privileges should be processed through established medical staff channels, be based solely on qualifications and competence, and be conditioned upon observance of the medical staff bylaws and the rules and regulations governing the anesthesia department. Privileges should be delineated in accordance with the ASA *Guidelines for Delineation of Privileges in Anesthesiology* and the *Suggestions*

to ASA Members for Delineation of Anesthesia Functions for Non-Physician Personnel.

2. Monitoring the quality of anesthesia care rendered throughout the hospital, including surgical, obstetrical, emergency, outpatient, psychiatric and special procedural areas. The ASA *Suggestions for a Record of Anesthesia Care to Facilitate Medical Audit* should be followed in order to provide the factual basis for such monitoring.

3. Recommending to the hospital administration and medical staff the type and amount of equipment and supplies necessary for administering anesthesia and for resuscitation.

4. Developing regulations concerning anesthetic safety.

5. Ensuring evaluation of the quality of anesthesia care throughout the hospital. Such evaluation should be based on the ASA *Guidelines for Peer Review in Anesthesiology.*

6. Establishing a program of continuing education for all personnel having anesthesia privileges, such program to include in-service training and to be based in part on the results of the evaluation of anesthesia care. Such program should follow the ASA *Guidelines for a Minimal Acceptable Program of Any Continuing Education Requirement.*

7. Participating in the development of, and enforcing, policies and procedures relating to the functioning of anesthesia personnel and the administration of anesthesia throughout the hospital.

8. Ensuring that qualified anesthesia personnel are available for the daily surgical schedule

and providing a schedule for 24-hour, 7-day a week availability of anesthesia care. Scheduling may be coordinated by the director or may be accomplished directly by scheduling between surgeons and anesthesiologists or indirectly by surgeons through the person responsible for developing the surgical schedule. Any scheduling mechanism should accommodate patient requests for specific anesthesiologists.

E. A description of the details of the operation of the anesthesia department, including all policies and procedures applicable to personnel in the department, should be compiled in a single set of rules and regulations or in a procedure and policy manual. Such policies and procedures must be consistent with the medical staff bylaws, the hospital charter and administrative regulations and local law, and should be based upon the ASA *Anesthesia Services: Procedure and Policy Manual* and other ASA guidelines and suggestions, adapted to suit local conditions.

In any event, the department of anesthesia must not be operated in a manner which restricts the patient's access to quality care or inhibits the competitive development of the specialty of anesthesiology.

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No. 82-1031

IN THE

Supreme Court Of The United States

October Term, 1982

JEFFERSON PARISH HOSPITAL DISTRICT No. 2 and EAST JEFFERSON HOSPITAL BOARD,
Petitioners

versus

EDWIN G. HYDE,
Respondent

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF *AMICUS CURIAE* OF THE ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS, INC. IN SUPPORT OF RESPONDENT, EDWIN G. HYDE

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QUESTION PRESENTED

Whether an exclusive contract entered into by and between a hospital and an anesthesiologist group to attend the hospital's patients is unlawful *per se* under the Sherman Antitrust Act, 15 U.S.C. §1, because it "ties" the patient's use of the hospital's operating rooms to the use of the hospital's anesthesiologists.

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versus

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ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF *AMICUS CURIAE* OF THE ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS, INC. IN SUPPORT OF RESPONDENT, EDWIN G. HYDE

INTEREST OF *AMICUS CURIAE*

Pursuant to Rule 36 of the Rules of this Court and with the consent of all parties,[1] the Association of American Physicians & Surgeons, Inc. (AAPS) respectfully files this brief *amicus curiae* in support of the Respondent, Edwin G. Hyde.

AAPS is a voluntary association formed in 1943 by private, practicing physicians and surgeons. AAPS is incorporated under and by virtue of the laws of the

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[1]Letters of Consent have been filed with the clerk.

State of Indiana, and has its principal office located in Burke, Virginia. AAPS is the largest association with nationwide membership in the United States devoted exclusively to representing the private, practicing physician and surgeon. AAPS has members in every state and territory in the United States, and in the District of Columbia.

Exclusive contracts between hospitals and anesthesiologists have been a long-time concern to the membership of the AAPS.[2] Fundamentally an organization dedicated to encouraging competitive practices in medicine and health care, the AAPS has always viewed exclusive contracts in hospitals with providers of anesthesiology as restraints upon trade. The AAPS, within its membership, represents many anesthesiologists nationwide. Nearly all enjoy practices which do not encompass exclusive contractual arrangements. Some face situations where exclusive contracts have been entered into by and between hospitals and competitor anesthesiologists. Those members know and understand the regrettable situation in which Edwin G. Hyde is placed. Most AAPS members, however, have practiced and continue to practice medicine in hospitals where multiple practioners of the specialty of anesthesiology enjoy vigorous practices.

The members of the Association of American Physicians and Surgeons, Inc., are private, practicing physicians and surgeons, and believe that quality as well as price fairness to the paying consumer of health care

[2]All arguments herein are equally applicable to exclusive contracts between hospitals and radiologists.

is best achieved through vigorous competition. The members of AAPS know only too well that health care has been, for many years, dominated by practices which are anticompetitive, and, consequently, those practices have denied entry into the market place of practitioner-competitors; prohibited innovation and alternative methods of health care delivery; and blocked practices aimed at allowing prices for services to be dependent upon competitive forces of the marketplace.[3] The members of the AAPS know that medicine has been traditionally controlled by a medical "cartel", be it the medical staff of a hospital, in conjunction with the institution, the county medical society, and/or state medical association. To the members of the Association of American Physicians & Surgeons, Inc., exclusive contracts are but another example of a threatened stagnation of competition in health care which, among

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[3]Cases heretofore decided by this Court illustrate the anticompetitive practices in medicine and health care. "Organized medicine" blocked the establishment of prepaid health clinics. *American Medical Association* v. *United States*, 317 U. S. 519 (1943). "Organized medicine" inhibited physician advertising. *In re American Medical Association*, 94 F.T.C. 701 (1979), *aff'd*, 638 F. 2d 443 (2nd Cir., 1980), *Aff'd* ____ U. S. ____, 102 S. Ct. 1744 (1982). A county medical society sought to organize its membership and negotiate fixed fees for health care services with insurance companies. *Arizona* v. *Maricopa County Medical Society*, ____ U. S. ____, 102 S. Ct. 2466 (1982). Reimbursement practices carried on between organizations of health care practitioners and insurance carriers were alleged to be vehicles whereby prices were potentially fixed (such as in the insurance claims "peer review" process), and patients were allegedly discouraged from using alternative forms of health care. *Union Labor Life Ins. Co.* v. *Pireno*, ____ U. S. ____, 102 S. Ct. 3002 (1982); *Blue Shield of Virginia* v. *McCready*, ____ U. S. ____, 102 S. Ct. 2540 (1982).

other things, will rigidly maintain a price structure for which no market forces will exist to lower or make more reasonable, and will discourage entry into the market of any and all competitive forces.

Accordingly, it is important to the members of the Association of American Physicians & Surgeons, Inc., to present facts which would illustrate how exclusive contracts, in truth, must be viewed, and, how hospitals and their medical staffs interact with respect to exclusive contracts.

For all the foregoing reasons and purposes, AAPS files the within brief *amicus curiae* in support of the Respondent, Edwin G. Hyde.

SUMMARY OF ARGUMENT

The issue in this case is whether an exclusive contract entered into by and between a hospital and an anesthesiologist group to attend the hospital's patients is unlawful *per se* under the Sherman Antitrust Act, 15 U.S.C. § 1, because it "ties" the patient's use of the hospital's operating rooms to the use of the hospital's anesthesiologists.

A. Practically speaking, an exclusive contract to perform anesthesiology entered into by and between a hospital and an anesthesiologist is, by its nature, anti-competitive. Since only one provider (or provider group) performs all anesthesiological services, other competitor-providers in the specialty are denied admission to the medical staff of the hospital, or, if they have hospital medical staff privileges, the same are revoked. Competing providers are excluded.

As a result of any exclusive contract to provide the services of a medical specialty, various inner-hospital and inner-hospital medical staff competitive factors are eliminated, and, accordingly, the price or prices for the medical specialty services will receive no stimuli to decrease, and will always spiral upward. As well, quality, also dependent upon competitive market factors, will be adversely affected.

B. Exclusive contracts in anesthesiology are, by no means, an old phenomenon. They are, in fact, quite new as a national impetus to implement among hospitals. Accordingly, to affirm the Court below would not affect hospitals generally. However, if the Court below is not affirmed many competing health care providers will be excluded from competition, and young providers denied entry into existing markets.

C. The hospital is always the dominant force in its relevant health care market. That market is quite small and well-defined. The hospital's market consists of that area within which the physicians and surgeons on its medical staff maintain their offices and residences, and, where would-be patients may conveniently and speedily be taken to the hospital. The foregoing is true since patients are admitted into the hospital through two channels. First, the patient's physician or surgeon admits him or her to the hospital where the provider enjoys admitting privileges. Such represents the vast majority of hospital admissions. If a patient is admitted through a means other than the foregoing, it is because of convenience of location. Therefore, within the area where its staff physicians

maintain their offices and residences and where the patients may conveniently or speedily be admitted, the hospital "dominates" the market in the provision of its environment within which health care services are offered. A hospital, therefore, possesses sufficient power in the various tying markets to coerce the purchase of tied "products".

D. Exclusive contracts by and between hospitals and anesthesiologists are "tying arrangements" and, accordingly, are *per se* violations of the Sherman Act. Since the same standards for the application of the antitrust laws must apply to health care as any other industry, the instant contract must be viewed with the same light this court viewed the purposes of the Sherman Act in *Northern Pacific Ry. Co.* v. *United States,* 356 U. S. 1 (1958). And, as physicians and surgeons are "individual competing entrepreneurs," combinations or contracts which restrain trade entered into by them should be viewed harshly. Here, since the hospital has the market power to control access to its operating rooms, the exclusive contract coerces a patient to utilize the exclusive anesthesiologist. As such it is a *per se* violation of the Sherman Act. *Northern Pacific Ry. Co.* v. *United States,* 356 U. S. 1 (1958); *Arizona* v. *Maricopa County Medical Society,* —— U. S. ——, 102 S. Ct. 2466 (1982).

E. The defense that exclusive contracts insure "quality health care" cannot pass muster since quality, like price fairness, is dependent upon the interplay of those market factors created by competition. The ex-

clusive contract eliminates all of the market factors which competition insures.

F. The exclusive contract is not a verticle integration. It is not an employment by the hospital of a health care specialist. Rather, the exclusive contract recognizes the anesthesiological group as private, practicing providers. They submit their own statements for services rendered.

Further, the hospital is not similar to a manufacturer at the end of process of production involving "levels" of jobbers or dealers. Instead, the hospital provides an atmosphere and "place" where "independent, competing entrepreneurs" provide health care services. The medical staff consists of many providers. It is organized by bylaws entered into with the hospital. Admission to the medical staff and consulting regarding medical procedures are, fundamentally, medical staff decisions. Accordingly, the relationships within a hospital are horizontal, not verticle.

As the exclusive contract recognizes the private, practicing provider status of the anesthesiological group, and, recognizes said provider group as part of an autonomous medical staff which is the fundamental decision-making body in the institution, the relationships are, indeed, horizontal. If the hospital sought to employ the anesthesiologists, it would have "employed" them, not awarded an exclusive contract. The exclusive contract must be viewed under the *per se* rule, and must be deemed a violation of the Sherman Act.

ARGUMENT

I

EXCLUSIVE CONTRACTS BETWEEN HOSPITALS AND ANESTHESIOLOGISTS ARE, BY THEIR NATURE ANTICOMPETITIVE

Exclusive contracts between hospitals and anesthesiologists are, practically speaking, anticompetitive. Simply, the hospital and its medical staff determine that one provider or one provider group shall perform all of the anesthesiological work in the institution. New providers coming into the market covered by the hospital are barred. Existing provider competitors are prevented from continuing their practice with the institution of the exclusive contract with the contracting provider.

Importantly, most exclusive contracts to provide anesthesiological services include, within their terms, agreements respecting price. AAPS members are aware of exclusive contracts which stipulate the prices which must be charged by the provider for each function or service offered. The instant case, as well, provides evidence of agreement between the hospital and the exclusive contractor relative to the price or prices for anesthesiological services.

Petitioners' argument regarding the long-standing and traditional practice of providing anesthesiology services through exclusive contracts is not well taken. Many hospitals have never instituted such practices. Most AAPS members who are anesthesiologists have practiced their specialty without such contracts. They represent specialists from all across the nation. Only

recently have AAPS members detected a national impetus among hospitals and hospital administrators to encourage entry into exclusive contracts with certain specialties. As a result, thousands of practicing anesthesiologists face the growing threat of being excluded from practicing their profession. Manifestly, exclusive contracts have not been uniformly utilized nationally. Their attempted wide-spread use is but a very recent phenomenon.

Where many providers of anesthesiological services may be excluded from practicing their specialty through such exclusive contracts, the paying consumer of health care services (patient, insurer or employer), as well, faces a bitter problem. With the advent of an exclusive contract between a hospital and an anesthesiologist, no incentives will exist to provide the services at lower cost. The exclusive contract provides a built-in guarantee that the cost for such health care services will only increase. No inner-hospital or inner-hospital medical staff competitive factors will remain to encourage fair pricing of the services rendered. Irrespective of whether a hospital is incorporated under the "non-stock, non-profit" corporation laws of its state, it nevertheless evidences a profit motive. Naturally, the members of the medical staff of the hospital, including anesthesiologists, have a definite profit motive. Though AAPS members applaud the profit motive (as Petitioners apparently do), exclusive contracts are abhorrent to all concepts of economic fairness. Accordingly, they are a nightmare for the paying consumer.

The exclusive contract eliminates any and all incentives to reduce or stabilize price or utilization. To that question the Court below addressed itself with particular force. The Court recognized that in anesthesiology much of the work is performed not by the anesthesiologist, but by anesthetists whose time is billed by the hospital to the patient. The more the anesthesiology department is controlled by the hospital administration, the greater the hospital's billing. And, irrespective of whether the anesthesiology provider with whom the hospital has contracted is lower-priced initially, from the date of the exclusive contract forward, no market incentives exist for either the hospital or the contracting professional to lower or stabilize price or utilization.

Unequivocally, exclusive contracts are neither a traditionally-accepted form of practice nor a universally-adopted one. As a national impetus, they are quite new. As such, their impact will force many health care providers in the relevant specialties out of business. Those providers otherwise would compete with their fellow providers in anesthesiology. Exclusive contracts, as well, will prevent new providers from entering a given market, and, will eliminate all those inner-hospital and inner-hospital medical staff market factors which protect the paying consumer from ever-increasing costs.

In every sense, exclusive contracts by and between hospitals and anesthesiologists restrain trade.

II

THE HOSPITAL IS ALWAYS THE DOMINANT FORCE IN ITS RELEVANT MARKET

Hospitals, fundamentally, receive patients through two channels. First, patients *are sent* to a particular hospital because their doctor is a staff member. Second, patients *choose* a hospital because of its close proximity to their home. For the most part a patient is admitted to a particular hospital because of his or her doctor. Patients generally do not request a specific hospital. As the Court noted below, the prevalence of third-party payment of health care bills eliminates the incentive to compare the relative cost effectiveness of competing hospitals. Likewise, most patients rely upon their physician or surgeon to inform them of the quality of medical care, and generally such a discussion is avoided when the doctor simply tells a patient, "I'm going to admit you to _____ hospital." The hospital in which the patient is admitted is one in which the physician or surgeon enjoys admitting privileges.

Where a patient has been involved in an accident or is in the midst of an emergency, he or she always chooses the hospital closest to home. When a patient chooses to enter a hospital, the hospital chosen is, customarily, close to family, friends and home.

It has been the universal experience of AAPS members that the above factors represent the reasons for the selection of one hospital over another. Accordingly, the Court below infused a very healthy and long-overdue realism in its opinion when it found the defi-

nition of the hospital's relevant market established by the District Court to be in error.

Unequivocally, economic concerns do not form the basis for most patients choosing one hospital over another. These days most patients do not pay the total medical and hospitalization bill. It is unrealistic to assert that most patients would be concerned about costs when third-party payers are paying for upwards of eighty percent of the health care services.

A hospital's relevant market is the relatively small geographic area which surrounds it. Most of its medical staff members choose to apply to the medical staff because of the close proximity of the hospital to their offices and homes. They may easily make their rounds during the day, and may make emergency calls at night without driving across town. Within that geographic area where its active medical staff members have established their offices, and, where would-be patients find it convenient to be admitted, the hospital reigns as the dominant force in the health care market.[4]

Irrespective of what Petitioners offer as the relevant market for a given hospital, the foregoing is *universally* true. The Court below was positively correct in its assessment of a hospital's market.

As a hospital possesses sufficient market domination within its geographic area, it possesses, as well, the power in various tying markets to coerce the pur-

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[4]The foregoing is underscored by the national trend among hospitals to construct their own medical offices adjacent to the hospital, and encourage admitting staff members to rent office space in such structures.

chase of tied "products." To deny that, the AAPS submits, is to deny the realities of the provision of health care today.

III

EXCLUSIVE CONTRACTS FOR ANESTHESIOLOGISTS ARE "TYING ARRANGEMENTS" AND, AS SUCH, ARE *PER SE* VIOLATIONS OF THE SHERMAN ANTITRUST ACT

A. The Same Standards for the Application of the Federal Antitrust Laws Which Have Been Generally Applied Also Apply to Medical Care.

Mr. Justice Hugo Black eloquently discussed the purpose of the Sherman Antitrust Act. He wrote,

> The Sherman Act was designed to be a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade. It rests on the premise that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic, political and social institutions. But even were that premise open to question, the policy unequivocally laid down by the Act is competition. And to this end, it prohibits "Every contract, combination or conspiracy in restraint of trade or commerce among the several states."

Northern Pacific Ry. Co. v. *United States,* 356 U. S. 1, 4-5 (1958).

For many years health care interests and "organized" medicine have sought to be viewed in a different light than other sectors of the American economy. To a degree, they were successful.

However, this Court, in 1982, eliminated what lines of difference had been drawn when it handed down its opinion in *Arizona* v. *Maricopa County Medical Society*, —— U. S. ——, 102 S. Ct. 2466 (1982). Observed this Court,

> Nor does the fact that doctors—rather than nonprofessionals—are the parties to the price-fixing agreements support the respondents' position. In *Goldfarb* v. *Virginia State Bar*, 421 U. S. 773, 788, n. 17 [95 S. Ct. 2004, 2013, n. 17, 44 L. Ed. 2d 572] (1975), we stated that the "public service aspect, and other features of the professions, may require that a particular practice, which could properly be viewed as a violation of the Sherman Act in another context, be treated differently." See *National Society of Professional Engineers* v. *United States*, 435 U. S. 679 [98 S. Ct. 1355, 1367, 55 L. Ed. 2d 637] (1978). The price-fixing agreements in this case, however, are not premised on public service or ethical norms. The respondents do not agree, as did the defendants in *Goldfarb* and *Professional Engineers*, that the quality of the professional service that their members provide is enhanced by the price restraint. The respondents' claim for relief from the *per se* rule is simply that the doctors' agreements not to charge certain insureds more than a fixed price facilitates the successful marketing of an attractive insurance plan. But the claim that the price restraint will make it

easier for customers to pay does not distinguish the medical profession from any other provider of goods or services.

We are equally unpersuaded by the argument that we should not apply the *per se* rule in this case because the judiciary has little antitrust experience in the health care industry. The argument quite obviously is inconsistent with [*U. S.* v.] *Socony-Vacuum* [*Oil Co.*, 310 U. S. 150, 60 S. Ct. 811, 84 L. Ed. 1129]. In unequivocal terms, we stated that, "[w]hatever may be its peculiar problems and characteristics, *the Sherman Act, so far as price-fixing agreements are concerned, establishes one uniform rule applicable to all industries alike.*" 310 U. S., at 222 [60 S. Ct. at 843]. We also stated that "[t]he elimination of so-called competitive evils [in an industry] is no legal justification" for price-fixing agreements, *Id.*, at 220, [60 S. Ct. at 843] yet the Court of Appeals refused to apply the *per se* rule in this case in part because the health care industry was so far removed from the competitive model. Consistent with our prediction in *Socony-Vacuum, Id.*, at 221 [60 S. Ct. at 843] the result of this reasoning was the adoption by the Court of Appeals of a legal standard based on the reasonableness of the fixed prices, an inquiry we have so often condemned. *Finally, the argument that the per se rule must be rejustified for every industry that has not been subject to significant antitrust activity ignores the rationale for per se rules,* which in part is to avoid "the necessity for an incredibly complicated and prolonged economic investigation into the entire history of the industry involved, as well as related industries, in an effort to determine at large

> whether a particular restraint has been unreasonable—an inquiry so often wholly fruitless when undertaken." *Northern Pac. R. Co.* v. *United States, supra* 356 U. S. at 5 [78 S. Ct. at 518]. (Emphasis added).

Arizona v. *Maricopa County Medical Society,* —— U.S. ——, 102 S. Ct. 2466, 2475-77 (1982).

Unequivocally, this Court has left no room for discussion regarding whether the federal antitrust laws, and the *per se* rule of those laws, apply to health and medical care. Accordingly, the purposes of the antitrust laws, as espoused by Mr. Justice Black in *Northern Pacific Ry. Co.* v. *United States,* 356 U. S. 1 (1958), must apply to health and medical care. That application of the federal antitrust laws to health and medical care is underscored by this Court's reference to physicians and surgeons as "individual competing entrepreneurs" in *Arizona* v. *Maricopa County Medical Society,* —— U. S. ——, 102 S. Ct. 2466 (1982). The AAPS submits that physicians and surgeons are, in fact, "individual competing entrepreneurs"; that they conduct their practices as such; and that they perceive themselves, in economic terms, as competitors.

As physicians and surgeons are "individual competing entrepreneurs," the exclusive contract which is the subject of the within action, by its very nature, must be violative of the Sherman Act, 15 U.S.C. §1. The exclusive contract, as outlined hereinabove, prevents Edwin G. Hyde, M.D., a competing entrepreneur, from entering the relevant market and competing. For anesthesiologists who presently compete in hospitals,

the entry into such an exclusive contract by the hospital and a single provider will eliminate many of them from competition. As outlined hereinabove, the exclusive contract forecloses those competitive factors found in the inner-hospital and inner-hospital medical staff market from favorably affecting the price of anesthesiology. With an exclusive contract, the price for anesthesiology services will be fixed, and there will be no market incentive for that price to ever decrease or stabilize. The profit motive of both the hospital and contracting anesthesiologist will continually pressure the fixed price upward.

B. The Exclusive Contract is a "Tying Arrangement"

The exclusive contract between the hospital and anesthesiologist group is, indeed, a "tying arrangement" as well as a basic restraint upon trade. As stated in *Northern Pacific Ry. Co.* v. *United States,* 356 U. S. 1, 5-6 (1958), "a tying arrangement may be defined as an agreement by a party to sell one product but only on the condition that the buyer also purchases a different (or tied) product, or at least agrees that he will not purchase that product from any other supplier." As indicated in *Northern Pacific,* the seller of the "tying product," here, the hospital, must have some "control or dominance" over the product it sells. *Id.* Mr. Justice Black referred to that "control or dominance" as being sufficient to exercise "power and leverage" in the market for the tied product. *Id.*

This Court further defined the confines of that "control or dominance" in the market for the tying product in *Northern Pacific*. Mr. Justice Black wrote,

> While there is some language in the Times-Picayune opinion which speaks of "monopoly power" or "dominance" over the tying product as a necessary precondition for application of the rule of per se unreasonableness to tying arrangements, we do not construe this general language as requiring anything more than sufficient economic power to impose an appreciable restraint on free competition in the tied product (assuming all the time, of course, that a "not insubstantial" amount of interstate commerce is affected)

Northern Pacific Ry. Co. v. *United States*, 356 U. S. 1, 11 (1958).

Sufficient market power over the tying product to exercise power and leverage over the market for the tied product is the standard.[5]

Here, the hospital, within the market place it dominates—the area where its medical staff members maintain their medical offices and residences and the area where would-be patients may enter the hospital conveniently and quickly—controls absolutely the rooms, equipment and personnel necessary for the use of the surgeons and other physicians who perform operations. The hospital has the necessary "control or dominance" over the product it sells.

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[5]Compare *Northern Pacific Ry. Co.* v. *United States*, 356 U. S. 1 (1958); *International Salt Co.* v. *United States*, 332 U. S. 392 (1947); *Time-Picayune Pub. Co.* v. *United States*, 345 U. S. 594 (1953); and *IBM Corp.* v. *United States*, 298 U. S. 131 (1936).

By entering into an exclusive contract with an anesthesiologist, the hospital, indeed, "ties" its product to the use of the exclusive anesthesiologist. In order for any patient to receive any surgical service in the hospital, he or she *must* use the anesthesiologist under contract.

The exclusive contract, here, is a classic "tying arrangement," and, as such, is a *per se* violation of the Sherman Antitrust Act. *Northern Pacific Ry. Co.* v. *United States,* 356 U. S. 1 (1958).

The buyers of health care services, contrary to the assertions of Petitioners, do exercise choice regarding anesthesiologists. AAPS member anesthesiologists have competed for business in the past, and do now. Just as patients listen to their own private physicians and surgeons regarding what hospital in which they will be admitted, patients also, through their physicians and surgeons, choose an internist, surgeon, heart specialist, urologist, anesthesiologist, etc.

Unequivocally, referrals from physician to physician enable a patient to make choices. Accordingly, the United States Court of Appeals was correct when it addressed the exclusive contract as a vehicle which undermined patient choice.

As the foregoing is true, any "tying arrangement" involving the hospital—which provides the atmosphere or "place" where certain health care is provided—and a provider of a specialty service in health care undermines the policy of the Sherman Act that "competition rule(s) the marts of trade." To paraphrase Mr. Justice Black, the exclusive contract conditions the sale of

the hospital as a "place" where certain health services are provided on the purchase of the specialty service. The seller—the hospital—thereby coerces the abdication of the buyer's—the patient himself or herself or through his or her physician or surgeon—independent judgment as to the merits of the "tied" specialty service, "and insulates the specialty service from the competitive stresses of the open market." *Northern Pacific Ry. Co.* v. *United States,* 356 U. S. 1, 10 (1958).

The exclusive contract must be a *per se* violation of the Sherman Act.

C. Any Defense of Petitioners That the Exclusive Contract Enhances Quality Medicine is Not Well Taken

Often in health care antitrust cases, the defense of "quality" is raised. Such was true in *American Medical Ass'n* v. *United States,* 317 U. S. 519 (1943); *In re American Medical Ass'n,* 94 F.T.C. 701 (1979), *aff'd* 638 F. 2d 443 (2d Cir., 1980), *aff'd* —— U. S. —— 102 S. Ct. 1744 (1982); *Arizona* v. *Maricopa County Medical Society,* —— U. S. ——, 102 S. Ct. 2466 (1982); and *Blue Shield of Virginia* v. *McCready,* —— U. S. ——, 102 S. Ct. 2540 (1982). AAPS, unequivocally, does not state here that legitimate quality of care concerns are unimportant. They are important. Quality of care, however, has often been used by the health care industry as a convenient smokescreen for behavior which does not have quality of care as its rationale at all. In health care, particularly, it is easy to pose the defense of quality of care to legitimize a host of anticompetitive activities.

Here, quality could hardly be said to have been enhanced by an exclusive contract. Rather, AAPS believes that the commentary of Mr. Justice Black in *Northern Pacific Ry. Co.* v. *United States,* 356 U. S. 1, 5 (1958) to be most appropriate when he wrote,

> . . . the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic, political and social institutions.

AAPS believes that the foregoing language is the foundation for the federal antitrust laws, and that no defense of "quality" here should cause the instant "tying arangement" to be treated differently than in other industries.

IV

AN EXCLUSIVE CONTRACT BETWEEN A HOSPTAL AND AN ANESTHESIOLOGIST IS NOT A VERTICAL INTEGRATION, BUT, RATHER, A HORIZONTAL ARRANGEMENT BETWEEN PROVIDERS, AND, ACCORDINGLY, THE *PER SE* RULE APPLIES

The argument heretofore raised by the Attorney General of the United State, as *amcus curiae,* that an exclusive contract between a hospital and an anesthesiologist is a vertical integration, and, accordingly, is not subject to the *per se* analysis is totally fallacious. AAPS states that even if the Attorney General could make a plausible argument for his proposition (which

he cannot), so what? Exclusive contracts of the type herein discussed restrain trade by eliminating competition, blocking new entrants into a given market, and cancelling all market forces which favorably affect, among other things, the price of the service and product. No narrow, technical hairsplitting may salvage a practice so adverse to the fundamental principles embodied in the Sherman Antitrust Act.

Unquestionably, exclusive contracts between hospitals and anesthesiologists cannot be viewed as verticle integrations. The relationships between a hospital and the services and products offered by the members of its medical staff involved in all the varied specialties, e.g. surgery, internal medicine, urology, radiology, anesthesiology, ophthalmology, oral surgery, obstetrics and gynecology, proctology, neurology, among others, and even non-medical doctor specialties like podiatry, cannot be viewed as the Attorney General seeks this Honorable Court to examine them.

Undeniably, those relationships between a manufacturer and its various dealers or jobbers differ from the relationships between a hospital and the individual providers of medical and surgical care on its medical staff. Health care, as delivered in a hospital setting, does not encompass separate "levels" of delivery as manufacturing encompasses "levels" of production. The most dramatic difference in the two models is found in the salient fact that decisions made with respect to the delivery of health care in a hospital are not necessarily made by the hospital but by the individual providers of medical care on its medical staff.

Medical staffs in hospitals—public and private—are autonomous, self-governing bodies composed of competitors in the practice of medicine's varied specialties.

Customarly, when an anesthesiologist seeks admission to the medical staff of a hospital, he or she must first be approved by the Credentials Committee and Executive Committee of the Medical Staff. If the anesthesiologist is not approved, an *ad hoc* committee of medical staff members conducts a hearing on the question. Though the hospital governing board usually has the ultimate authority to approve medical staff membership, the medical staff, in most instances, makes the critical decisions. The use of anesthesiology is controlled by consults with surgeons and, possibly, physicians of other specialties. Again, the use of the professional service is determined by inner-hospital medical staff decision-making, not by the hospital.

The autonomy of the medical staff is underscored by the fact that medical staffs, uniformly, have bylaws—contractual in nature—entered into by and between them and the hospitals. Those bylaws traditionally create the departments into which medical staffs are divided, including the department of anesthesiology. The by-laws, as well, provide procedures for medical staff admissions, including the committees before which an applicant must appear in order to receive consideration for staff membership.

In typical larger medical staffs there are multiple surgeons, multiple internists, multiple urologists, etc. In fact, there are usually so many of each specialty that

they are, in the medical staff bylaws, departmentalized, with each department electing its own officers.

As stated hereinabove, the decision of what "specialist" to use, be that specialist an anesthesiologist, surgeon, internist, obstetrician, etc., is made either by the patient, or, in most cases, by the patient's personal, physician or surgeon based upon that physician's or surgeon's judgment of who is the better professional or, simply, what professional the physician or surgeon likes or with whom he or she better works. Thus, the choice of anesthegiologist in a non-exclusive contract context, is usually determined by market forces which originate within the hospital medical staff.

Whether a particular physician or surgeon "likes" or "prefers" a particular anesthesiologist, would, most likely, not be considered if the anesthesiologist has a bad reputation, is incompetent, charges exhorbitantly or is difficult to work with. Only the *market* can insure quality; only the *market* can best insure fair pricing.

All of the foregoing are inner-hospital medical staff factors which the Attorney General has failed to consider.

Manifestly, there is no verticle integration here.

Because of the foregoing, one cannot view the hospital as the manufacturer at the end of a process involving dealers and jobbers. There exists absolutely no comparison.

The hospital offers only a "place" where "independent competing entrepreneurs" offer their special health care services. The hospital is not akin to the manufacturer at the end of a long process of manu-

facturing. Rather, the hospital offers but the "place" for the performance of health care services. It is a "place" where multiple surgeons, multiple internists, multiple urologists, multiple obstetricians and gynecologists, multiple gastroenterologists, multiple anesthesiologists, etc., all departmentalized and all autonomously organized and self-governing, compete with one another in the offering of their specialty within the hospitals walls.

AAPS submits that if the hospital actually seeks to vertically integrate the medical professionals into itself it would *employ* them.

Petitioners assert that the exclusive contract here is a contract of employment. AAPS states that the exclusive contract here is no such thing! If Petitioners meant to *employ* the anesthesiologists, they would not have entered into an exclusive contract, but would have *employed* the group. The exclusive contract here recognizes that the anesthesiologist is a private, practicing provider group performing professional health care services. The anesthesiologists under the exclusive contract are members of the medical staff capable of holding elective office, and representing all private, practicing medical staff members. The anesthesiologists under the exclusive contract submit their own statements for services rendered. The group is not paid a salary, nor are taxes and social security withheld from payment. It is interesting to note that Petitioners must recognize the difference between the exclusive contract as a horizontal arrangement, and, employment as a verticle integration since so much of their defense

is based upon their assertion that the exclusive contract, here, is an employment question. Such, of course, does not pass muster as a matter of fact.

In all respects, the anesthesiologist under the exclusive contract is a private, practicing physician. The exclusive contract at issue here is no verticle integration. Rather, because hospitals rely upon an autonomous medical staff for most decision-making and fact-finding with regard to admissions to the staff of the hospital, and rely upon the medical staff for nearly all decisions regarding the administration of health care services, the relationship is purely horizontal. As such, the *per se* rule must apply.

CONCLUSION

For all the reasons set forth above, the *amicus curiae* urges that the decision of the United States Court of Appeals for the Fifth Circuit be affirmed.

Respectfully submitted,

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No. 82-1031

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT No. 2 and EAST JEFFERSON HOSPITAL BOARD,

Petitioners

v.

EDWIN G. HYDE, M.D.,

Respondent.

On Writ of Certiorari to the United States Court of Appeals For the Fifth Circuit

BRIEF AMICUS CURIAE OF THE COLLEGE OF AMERICAN PATHOLOGISTS IN SUPPORT OF PETITIONERS

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v.

Edwin G. Hyde,
Respondent.

On Writ Of Certiorari To The United States
Court Of Appeals For The Fifth Circuit

CONSENT

On behalf of petitioners Jefferson Parish Hospital District No. 2 and East Jefferson Hospital Board, the undersigned hereby consents, pursuant to Rule 36 of the Rules of the Supreme Court, to the filing of a brief amicus curiae on behalf of the College of American Pathologists in this matter.

HENRY S. ALLEN, JR.
Counsel for Petitioners

DATED: April 1, 1983

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CONSENT

On behalf of respondent Edwin G. Hyde, the undersigned hereby consents, pursuant to Rule 36 of the Rules of the Supreme Court, to the filing of a brief amicus curiae on behalf of the College of American Pathologists in this matter.

JOHN M. LANDIS
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DATED: April 4, 1983

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BRIEF AMICUS CURIAE OF THE COLLEGE OF AMERICAN PATHOLOGISTS IN SUPPORT OF PETITIONERS

INTEREST OF AMICUS CURIAE

This brief is submitted in support of petitioners by the College of American Pathologists. It is being filed with the consent of all parties.[1]

The College of American Pathologists and its approximately 9,000 pathologist members have a substantial in-

[1] Copies of the parties' consents are printed in the Appendix.

terest in the question presented in this case. Pathologists are physicians who specialize in applying medical knowledge and judgment to the testing and analysis of biologic specimens in connection with the diagnosis and treatment of human disease. Services performed by pathologists include, for example, the following:

(a) Examination of human tissue as it relates to the diagnosis or treatment of disease;

(b) Solving of problems relating to the identification of compatible blood for transfusions;

(c) Analysis of hematology smears and test results;

(d) Interpretation and reporting of results of specific procedures; and

(e) Performance of quality assurance services so that every test yields a medically reliable result.

Because these services are performed for hospital inpatients, pathologists customarily enter into contracts with hospitals. Available data suggest that a substantial portion of these contracts provide for exclusive arrangements similar to that found unlawful *per se* by the court of appeals in this case.[2]

Although the arrangements between pathologists and hospitals differ in certain respects from those involving anesthesiologists, the blunt rationale of the decision below threatens to disrupt many such arrangements. Thus, if affirmed, the decision will adversely affect the contractual relationships of many of the College's members. Moreover, to the extent that exclusive contracts enhance the quality of medical care, the decision below is inimical to the interests of patients whom the College's members are committed

[2] See American Medical Association, Center for Health Policy Research, *SMS Report* (Feb. 1982); see also Feldstein & Roehrig, *An Analysis of Exclusive Contracts and Closed Staffing in Hospitals: The Effects on Competition* (a report to the FTC).

to serve. For these reasons, the College of American Pathologists offers this brief as Amicus Curiae.

STATEMENT OF THE CASE

This case involves an antitrust challenge by the respondent, Edwin G. Hyde, M.D., to a contract between East Jefferson General Hospital and a professional medical corporation, Roux & Associates, under which anesthesiology services in the Hospital would be provided exclusively by the corporation's physicians. The district court concluded that the contract did not unreasonably restrain trade and thus did not violate the Sherman Act. 513 F. Supp. 532. The court of appeals reversed. 686 F.2d 286. It concluded that petitioners had tied the sale of distinct medical services (i.e., surgical facilities and anesthesia) and that the tie was unlawful *per se* because, in its view, the Hospital had sufficient market power to coerce the purchase of anesthesiology services.

SUMMARY OF ARGUMENT

Applying precedent holding that commercial tying arrangements are unlawful *per se,* the court of appeals held that an exclusive contract between a hospital and a group of hospital-based physicians was a tie and therefore violative of the antitrust laws. It reached this conclusion without any analysis of the competitive significance of the contract. The contract in question, however, is not a tie. It involves no forced purchase of a second distinct commodity. Moreover, it serves to facilitate competition by promoting quality of service.

Even if the contract were properly characterized as a tie, however, application of the *per se* rule would nonetheless be inappropriate. This Court has repeatedly admonished that the fact that a restraint operates upon a profession as distinguished from a business is relevant in determining whether that particular restraint violates the Sherman Act. See, *e.g.*, *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, 778-779 n.17 (1975). In view of the unique medical context of the contract in question, the court of appeals should have considered the competitive significance of the arrangement rather than to strike down the arrangement by wooden invocation of the *per se* rule. The decision in *Arizona* v. *Maricopa County Medical Society*, ____ U.S. ____, 102 S.Ct. 2466 (1982), is not to the contrary. The *per se* rule was applied there because that case involved price fixing—not, as here, an arrangement designed to enhance the quality of patient care.

Application of the rule of reason leads to the conclusion that the contract in question is lawful because it promotes competition. Specifically, by enhancing the quality of care, it enables petitioner hospital to compete effectively with other hospitals. In addition, it promotes competition among hospital-based physicians to offer high quality services at the lowest cost in order to be selected for the exclusive position. For all these reasons, the court of appeals erred in using the antitrust laws to second-guess a reasonable judgment of a hospital and physicians regarding the most effective way in which to provide certain medical services to patients. Accordingly, its decision should be reversed.

ARGUMENT

I. EXCLUSIVE ARRANGEMENTS BETWEEN HOSPITALS AND HOSPITAL-BASED PHYSICIANS SHOULD BE JUDGED UNDER THE RULE OF REASON RATHER THAN THE PER SE RULE.

The court of appeals struck down as unlawful *per se* a contractual form that, as the district court found, is a "common practice in the health care industry." 513 F. Supp. at 540. Without substantial discussion, the court decided that the arrangement constituted a tie-in of distinct services "which a buyer should be able to obtain separately." 686 F.2d at 289. It concluded that the contract was thus illegal *per se*.

The contract in this case, however, is decidedly not a tie. The rule against tying arrangements is designed to prevent a seller from coercing the purchase of a distinct product that the buyer does not want. *Times-Picayune Publishing Co.* v. *United States*, 345 U.S. 594, 614 (1953). This case does not involve a purchase of a distinct service that the patient does not want. There is no demand for operations without anesthesiology. Rather, the patient expects both services to be provided together. Anesthesiology services are "an ancillary and necessary part" of surgery. See *Washington Gas Light Co.* v. *Virginia Electric & Power Co.*, 438 F.2d 248, 253-254 (4th Cir. 1971). They "may fairly be treated by the seller as inseparable" from the surgery. See *Dehydrating Process Co.* v. *A. O. Smith Corp.*, 292 F.2d 653, 655 (1st Cir.), cert. denied, 368 U.S. 931 (1961). In these circumstances, hospital rooms and anesthesiology services cannot correctly be regarded as distinct products for antitrust purposes. The *per se* rule of illegality is therefore not implicated at all.

In any event, "the rules governing tying arrangements are designed to strike solely at practices employed to impede competition on the merits." *Hirsh* v. *Martindale-*

Hubbell, Inc., 674 F.2d 1343, 1347-48 (9th Cir. 1978), cert. denied, No. 82-570 (Nov. 1, 1982). Where the arrangement "serves to facilitate competition by promoting product quality" no tying arrangement exists. *Id.* That is precisely the situation here. See pp. 10-12, *infra*.

Even if the contractual arrangement in question could be considered as a kind of tie-in, however, the court of appeals erred in applying the *per se* rule. The court should have heeded this Court's admonition that antitrust concepts which originated in other areas should not automatically be applied to the professions. *Goldfarb, supra*, 421 U.S. at 788-789 n. 17; *National Society of Professional Engineers* v. *United States*, 435 U.S. 679, 696 (1978). Professional practices are not interchangeable with commercial activities, and "[t]he public service aspect, and other features of the professions, may require that a particular practice, which could be properly viewed as a violation of the Sherman Act in another context, be treated differently." *Goldfarb, supra*, 421 U.S. at 788-789 n. 17. Indeed, this case bears out the wisdom of that observation—for it involves the striking down, *without any serious economic analysis*, of a contract which reflects the best judgment of a hospital and a physician group regarding how medical care can most efficiently be delivered.

The court of appeals erroneously believed that it was required to apply the *per se* rule by this Court's decision in *Arizona* v. *Maricopa County Medical Society*, ____ U.S. ____, 102 S.Ct. 2466 (1982). The Court held in that case that maximum fee agreements among physicians, as price-fixing agreements, were unlawful *per se* under the Sherman Act. The rationale of that decision, however, is limited to price fixing. Moreover, the Court suggested that a *per se* analysis is inappropriate for agreements that are "premised on public service or ethical norms" or that are alleged to enhance "the quality of the professional service." *Id.* at 2475.

The facts of this case are fundamentally different from those that led to application of the *per se* rule in *Maricopa*. First, this case does not involve price-fixing agreements, which have long been determined to be such naked restraints of trade as to warrant automatic condemnation under the Sherman Act. *United States* v. *Socony-Vacuum Oil Co.*, 310 U.S. 150, 218 (1940). Rather, exclusive contracts between hospitals and physicians "create relationships among hospitals, physicians, and patients that have no clear parallels in commercial practice."[3] In the context of such unique arrangements, particularly involving medical professionals, it is imperative for courts fully to consider the competitive significance of the arrangements. *Goldfarb*, *supra*.

Second, unlike the agreement at issue in *Maricopa*, the purpose of the exclusive contract between the hospital and the anesthesiology group in this case was "to enhance

[3] FTC Letter to Robert E. Nord, dated February 24, 1983, ("FTC Opinion Letter"), p. 3. In its letter, the FTC issued an opinion advising a hospital that a contract between the hospital and a physician group granting the group the exclusive right to provide radiology services to patients in the hospital did not violate the antitrust laws. The FTC concluded that the contract was "most closely analogous to a requirements contract, a type of exclusive dealing arrangement, that should be judged under the rule of reason in a fashion similar to that for more traditional vertical restraints." *Id.* at 7. In this regard the FTC expressly rejected the court of appeals' characterization of the contract in this case as a tie-in subject to a rule of *per se* illegality. *Id.* at 6. The FTC identified the considerations that it believes are relevant in determining the reasonableness of such arrangements: the extent of the markets for hospital and physician services involved in the contract, the purpose of the contract, its duration, the extent to which the contract deters entry, the extent of competition for the contract, and the benefits the hospital and the public derive from the contract. *Id.* at 7.

patient care," 513 F. Supp. at 541—a purpose lying at the core of the medical profession. As the district court found, the effect of the contractual arrangement was to improve "the quality of the professional services" that patients received. See *Maricopa, supra,* 102 S.Ct. at 2475. In addition, the contract demonstrably enhanced competition by "improving a hospital's ability to provide competent health care competitively." 513 F.Supp. at 544.

That the court of appeals' cursory analysis led it automatically to condemn an arrangement affording such benefits to patients underscores the necessity of considering the purposes and effects of petitioners' contract. The antitrust laws are, after all, a "consumer welfare prescription." *Reiter* v. *Sonotone,* 442 U.S. 330, 343 (1979). For these reasons, all other courts that have considered exclusive arrangements between hospitals and physicians have concluded that they are subject to a rule of reason.[4] Like the district court here, these courts have concluded that such arrangements do not necessarily have anticompetitive effects and that the particular arrangement at issue in each case did not unreasonably restrain trade.[5] The rule of reason, applied in this case, dictates the same result.

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[4] See *Smith* v. *Northern Michigan Hospitals, Inc.,* 1983-1 Trade Cases (CCH) ¶ 65,289 (6th Cir., Mar. 25, 1983); *Dos Santos* v. *Columbus-Cuneo-Cabrini Medical Center,* 684 F.2d 1346 (7th Cir. 1982); *Capili* v. *Shott,* 620 F.2d 438 (4th Cir. 1980); *Harron* v. *United Hospital Center, Inc.,* 522 F.2d 1133 (4th Cir. 1975), cert. denied, 424 U.S. 916 (1976); *Robinson* v. *Magovern,* 521 F. Supp. 842 (W.D. Pa. 1981), aff'd mem., 688 F.2d 824 (3d Cir. 1982), cert. denied, No. 82-415 (Nov. 1, 1982).

[5] As a means of efficiently integrating the provision of related medical services, such arrangements are properly viewed as vertical restrictions, analogous to requirements contracts. *Smith* v. *Northern Michigan Hospitals, Inc., supra,* 1983-1 Trade Cases at 69,706; *Dos Santos* v. *Columbus-Cuneo-Cabrini Medical Center, supra,* 684 F.2d at 1352; FTC Opinion Letter, *supra,* p. 6; see also *Continental T.V., Inc.* v. *GTE Sylvania, Inc.,* 433 U.S. 36 (1977).

II. THE EXCLUSIVE ARRANGEMENT AT ISSUE HERE PROMOTES COMPETITION AND THUS SATISFIES THE RULE OF REASON

Hospitals have the responsibility to provide patients with comprehensive medical care. In carrying out this responsibility, they must provide various products—clean, well-equipped hospital rooms, sanitary and modern surgical facilities, food, and so forth. It could not be seriously suggested that a hospital engages in an unlawful tie-in when it selects one contractor to provide meals or laundry services to patients rather than opening its rooms to a parade of outside vendors. Yet such a parade is precisely what the overbroad holding of the court of appeals would require.

More importantly, hospitals must make sure that medical services, including services performed by anesthesiologists, radiologists, and pathologists, are efficiently provided. Just as a hospital does not violate the antitrust laws when it selects a particular food vendor or laundry service to provide meals or linens, likewise it does not violate those laws when it chooses a group of hospital-based physicians to provide specialty services to patients.

A hospital can ensure the availability of the services of anesthesiologists, radiologists, and pathologists in a number of ways. It can open its staff to any qualified independently practicing individual, employ such specialists directly, or, as petitioners did, enter into an exclusive contract with a particular group of specialists. Which of these arrangements in a given situation will permit a hospital to dispense quality health care most efficiently will depend upon a variety of factors—including the scale of the hospital's operation, the range of skills and services offered by the physician group, the frequency of need for the specialists' services, and the extent to which these services must

be coordinated with other aspects of the patient's care. None of these arrangements, however, is necessarily anti-competitive.

Indeed, the medical and economic justifications for exclusive contracts between hospitals and hospital-based physicians were suggested by the findings of the district court in this case. The court found that a number of efficiencies resulted from the arrangement between petitioners and Roux: more certain 24-hour availability of services; improved control and standardization of procedures; efficient and less costly operation of the department, facilitated in part by the use of nurse anesthetists; flexibility and efficiency in scheduling operations; enhanced proficiency of physicians, nurses, and technicians with the anesthesiology equipment; better monitoring of medical standards; and less costly maintenance of equipment. 513 F. Supp. at 540.[8]

Similar improvements and efficiencies in the provision of patient care can be realized where the services of other specialists are engaged. Exclusive arrangements are com-

[8] The court of appeals rejected these efficiencies as justification for the contract, believing that they could be achieved by less restrictive alternatives. 686 F.2d at 292. As a practical matter, the court's "less restrictive" alternative standard would admit few if any competitive justifications, since it would be rare that some means of achieving a given business purpose could not be imagined that would result in a lesser restraint of trade. See *American Motor Loans, Inc.* v. *Holiday Inns, Inc.*, 521 F.2d 1230, 1249-1250 (3d Cir. 1975); cf. *Illinois Elections Board* v. *Socialist Workers Party*, 440 U.S. 173, 188 (1979) (Blackmun, J., concurring). In any event, whatever the relevance of "less restrictive" alternatives once an arrangement has been determined to be a tie-in, they are not dispositive of justifications advanced, as in this case, for not regarding the arrangement as a tie-in in the first instance. See *Hirsh* v. *Martindale-Hubbell, Inc.*, *supra*, 674 F.2d at 1347.

mon in the provision of medical services by members of Amicus College of American Pathologists. Pathology services must be available continuously throughout the day. Many pathology services depend upon highly sensitive laboratory instruments of which the care and calibration must be closely supervised. Analyses frequently require the coordinated work of numerous technicians and other nonphysician personnel, as well as the coordinated services of several sections of the laboratory—e.g., hematology, microbiology, clinical chemistry. In view of the scale and complexity of the pathology departments in many hospitals, it frequently would be impossible efficiently to organize their operations without the centralized control and accountability that exclusive arrangements afford.

By contributing to the efficient operations of the hospital, an exclusive arrangement promotes competition among hospitals both for patients and for members of the staff. See *Dos Santos* v. *Columbus-Cuneo-Cabrini Medical Center, supra,* 648 F.2d at 1353-1354; *Robinson* v. *Magovern, supra,* 521 F. Supp. at 919; FTC Opinion Letter, *supra,* at 4. As the district court found in this case, by "increasing the quality of medical care available," the exclusive contract enhanced competition among hospitals. 513 F. Supp. at 541.[7] Thus, the existence of an exclusive arrangement within a hospital merely shifts the focus of competition. Cf. *Continental T.V., Inc.* v. *GTE Sylvania Inc., supra,* 433 U.S. at 51-57.

In addition, an exclusive arrangement produces competition among different physician groups to be selected for the position offered by a hospital. See 513 F. Supp. at 541. Competition among physician groups for exclusive contracts can be a very effective means of producing high quality medical service at the lowest price. In fact, given the

[7] In the case of pathologists, additional competition is provided by independent laboratories whose services compete with those offered in hospitals.

practical difficulties facing patients in comparing the services of hospital-based anesthesiologists, radiologists, and pathologists, such competition is often more effective than would be unbridled competition among specialists within the departments of a single hospital. *Dos Santos, supra,* 684 F.2d at 1354.[8]

In any event, the contract at issue here certainly did not suppress competition. As the district court noted, East Jefferson Hospital competes in a market that includes at least twenty other hospitals providing the same surgical services. 513 F. Supp. at 541-542.[9] Patients and surgeons often ex-

[8] See also *Maricopa, supra,* 102 S. Ct. at 2485 n.13 (Powell, J., dissenting):

> "Medical services differ from the typical service or commercial product at issue in an antitrust case. The services of physicians, rendered on a patient-by-patient basis, rarely can be compared by the recipient. A person requiring medical service or advice has no ready way of comparing physicians or of "shopping" for quality medical service at a lesser price."

[9] The district court found that East Jefferson had no economic power within this market and thus could neither unreasonably restrain competition nor coerce the purchase of allegedly tied medical services. 513 F. Supp. at 540-543. The court's findings of fact were fully supported by the record. The court of appeals did not disagree with these findings. Indeed, it acknowledged that under a "traditional method of economic power analysis" the respondent had "failed to prove an illegal tying arrangement." 686 F.2d at 290. Instead, the court rested its conclusion that the Hospital had sufficient market power to warrant enjoining its conduct as a tie-in on "several market imperfections in the health care industry" which it believed "led patients to select the hospital closest to home" and to prefer nonprofit hospitals like East Jefferson. *Id.* Not only does the record in this case not support the court of appeals' de novo findings concerning the nature of competition in the health care industry, but the facts even as viewed by the court do not indicate that the Hospital had any market power of significance under the antitrust laws.

ercise the option of going to another area hospital. *Id.* Thus, the exclusive contract, involving only one hospital, affected only a small part of the market for anesthesiology services, ensuring that competition would exist between hospitals and between anesthesiologists at different hospitals. Moreover, the duration of the exclusive contract was only one year, short enough to ensure competition between anesthesiology groups seeking to obtain the contract at the time of its renewal.

Amicus College of American Pathologists submits that, for all the foregoing reasons, the appropriate analysis was set forth in *Smith* v. *Northern Michigan Hospitals, Inc.*, ____ F.2d ____, 1983-1 Trade Cases (CCH) ¶ 65,289 (6th Cir. Mar. 25, 1983). There, the Sixth Circuit sustained an exclusive contract between a hospital and a physician group for the provision of emergency room services. Noting that these services could be provided in a number of ways, the court concluded that the exclusive contract was "undisputedly legitimate" (*id.* at 69,708):

> "In the present case [the hospital] has only one emergency room through which to provide emergency services to the public. It was required to choose among alternative methods of providing this service in an effective, efficient, and medically prudent manner. We agree with the District Court that the defendant [hospital] chose to staff its consolidated emergency room with full-time specialists in emergency care for undisputedly legitimate financial and medical reasons. The appellants have failed to present any evidence which would contradict [the hospital's] manifestly legitimate and well-supported justification that full-time specialists trained as emergency room physicians provide medical services superior to those of generalists who rotate on a part-time basis while maintaining full private practices."

In other words, absent evidence of clear anticompetitive intent, courts should not use the antitrust laws as a vehicle

to second-guess the judgment of hospitals and physicians concerning the most efficient means of meeting the needs of patients.

CONCLUSION

For the foregoing reasons, Amicus College of American Pathologists suggests that the judgment of the court of appeals be reversed.

Respectfully submitted,

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No. 82-1031

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL
DISTRICT NO. 2 and
EAST JEFFERSON HOSPITAL BOARD,
Petitioners,

versus

EDWIN C. HYDE,
Respondent.

ON APPEAL FROM THE UNITED STATES
COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF AMICUS CURIAE OF LOUISIANA HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONERS, JEFFERSON PARISH HOSPITAL, DISTRICT NO. 2 AND EAST JEFFERSON HOSPITAL BOARD

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QUESTION PRESENTED

Whether an arrangement by which a hospital grants a group of physicians the exclusive right to render all anesthesia services at the hospital is a *per se* illegal tying arrangement under Section I of the Sherman Act. 15 U.S.C. §1 (1976).

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INTEREST OF THE AMICUS CURIAE

The Louisiana Hospital Association (hereafter referred to as "the Association") is a trade organization composed of one hundred thirty-six (136) hospitals and organized under the laws of the State of Louisiana. The Association is the largest organization representing the interest of hospitals in

Louisiana. The member hospitals cover the spectrum of the hospital industry in Louisiana. The Association has as members hospitals with as few as twenty-one (21) beds and hospitals with more than six hundred (600) beds. The Association's members range from small and rural hospitals providing primary care to major teaching tertiary care centers located in urban centers. The Association's members are representative of every form of ownership and corporate status currently existing in the hospital industry. The Association's membership is composed of public non-profit community hospitals, private non-profit hospitals, for-profit hospitals, religiously owned hospitals, federally owned hospitals, state-owned hospitals, university-owned teaching hospitals and hospital service district hospitals such as East Jefferson Parish Hospital Service District Number Two.

The Association's members are ever cognizant of their obligation to provide high quality medical care to their patients in an economic and efficient maner. The governing boards of member hospitals recognize that they are ultimately responsible for the quality of the medical care rendered in their institutions. The Association and its members are vitally concerned in this case because the decision of this Honorable Court will affect the manner in which hospitals fulfill their obligations to their patients.

SUMMARY OF ARGUMENTS

Amicus Curiae Louisiana Hospital Association respectfully submits that an exclusive contract by which a hospital grants to a select group of anesthesiologists the exclusive right to provide all anesthesiologist services at the hospital should be considered a vertical restriction analogous to an agree-

ment by a manufacturer to limit the number and location of their distributors in a given geographical area and, as indicated in *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 97 S.Ct. 2549, 53 L.Ed 2d 568 (1977), should be analyzed under the rule of reason.

Amicus Curiae Louisiana Hospital Association respectfully submits that the contractual arrangement between East Jefferson Hospital and Roux and Associates is not a *per se* illegal tying arrangement because there is an absence of two separate products or services. In this era of modern medicine and burgeoning medical malpractice liability, operating rooms are of no value without anesthesia services and vice versa. These services are sold together as a package and form one service, i.e. in-patient hospital surgical care.

Should it be determined that there exists a tying arrangement, such arrangement does not meet the test of *per se* illegality set forth in *United States Steel v. Fortner Enterprises*, 429 U.S. 610, 97 S.Ct. 861, 51 L.Ed. 2d 80 (1977) because there was no showing that East Jefferson General had the ability to raise prices, imposed burdensome conditions on patients, provided operating rooms that were unique or had some advantage not shared by competing hospitals.

Lastly, *Amicus Curiae* Louisiana Hospital Association respectfully submits that the Fifth Circuit erred in determining the relevant geographical market. According to the Fifth Circuit's guiding principle of a hospital's proximity to its patient population as the determinant of relevant geographical market, every hospital would constitute a separate and distinct relevant geographical market because area patients would prefer it to less proximate hospitals. Such an analysis

totally ignores the fact the hospitals compete on the basis of quality of their services and the availability of a large number of services. If all hospitals were of like quality and offered uniformly identical services, then, perhaps, the Fifth Circuit's holding would have some merit, but such a premise is totally divorced from the economic realities of the hospital industry.

ARGUMENT

The issue presented is whether an exclusive contract by which a hospital grants to a single group of anesthesiologists the exclusive right to render all anesthesia services at the hospital is a tying arrangement and illegal *per se* under Section I of the Sherman Act 15 USC §1 (1976). Section I of the Sherman Act 15 USC §1 (1976) states in pertinent part: "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal."

The Federal District Court for the Eastern District of Louisiana, after a bench trial on the merits, held that the contract was not a *per se* violation of Section I of the Sherman Act 15 USC 1 (1976). *Hyde v. Jefferson Parish Hospital Service District No. 2*, 513 F. Supp. 584 (1981). Furthermore, the trial court held that the exclusive contract was legal under the rule of reason analysis articulated in *Standard Oil Co. v. United States*, 221 U.S. 1, 31 S.Ct. 502, 55 L.Ed. 619 (1911). In its decision, the trial court made several findings. It found that it was common practice for hospitals to enter into exclusive contracts with physicians who are engaged in certain hospital-based specialties, such as anesthesiology, radiology, pathology, etc. to insure the availability of

these services to their patients. It found that generally a patient does not specifically select a certain individual to perform these services, which increases the hospital's responsibility to insure the quality of services it provides 513 F. Supp. 532 at 540. The court found that the exclusive arrangment insures twenty-four-hour coverage; aids in the control and standardization of procedures and the efficient and less costly operation of the department; lends flexibility to the scheduling of operations; permits the physicians, nurses and other technicians to develop a work routine and proficiency in the use of equipment; simplifies maintenance of equipment and minimizes equipment breakdown; and lastly, increases the Board's ability to monitor the medical standards exercised. 513 F. Supp. 532 at 540. The trial court determined that the provision of anesthesia services is a medical service separate from the other services provided by the hospital. The hospital charges the patient a separate charge for this service 513 F. Supp. 532 at 540. The trial court defined the relevant geographic market as the market area in which the seller operates and to which the purchaser can practically turn for supplies, *U.S. v. Phillipsburg National Bank and Trust Company*, 399 U.S. 350, 90 S.Ct. 2035 (1970). Since the evidence indicated that 70 percent of the patients from the East Bank of Jefferson Parish went to hospitals in the metropolitan New Orleans area, the Court determined that the relevant market included the east banks of Jefferson and Orleans parishes which contained over twenty hospitals. 513 F. Supp. 532 at 540. The trial court also determined that while it is likely that a patient would choose to go to a hospital closest to his home, that factor was not proof that East Jefferson Hospital is a strong economic power in the market in which it competes. 513 F. Supp. 532 at 542-543.

After determining that the exclusive contract was not a *per se* illegal tying arrangement, the trial court analyzed the arrangement under the rule of reason. Following the guidelines established by the Court in *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 95 S.Ct. 2004 (1975) and *National Society of Professional Engineers v. U.S.*, 435 U.S. 679, 98 S.Ct. 1335 (1978) the trial court determined that the anti-competitive effect on the practice of anesthesia in the relevant market was minimal. Furthermore, the contract did not prevent Dr. Hyde or any other anesthesiologist from practicing in any hospital other than East Jefferson in the relevant market. The trial court concurred in the belief expressed by legal commentators[1] that such a contract enhanced the hospital's ability to compete.

The appellate court, citing the definition of a tying arrangement contained in *Northern Pacific Ry. v. United States*, 356 U.S. 1, 78 S.C. 514, 2 L.Ed. 2d 545 (1958) determined that a tying arrangement existed because ". . . it is clear that users of the hospital's operating rooms (the tying product) are also compelled to purchase the hospital's chosen anesthesia service (the tied product). It is also clear that we are dealing with two distinct services which a buyer should be able to obtain separately." 686 F.2d 286 at 289. The appellate court next determined that the trial court "applied a traditional method of economic analysis in this case . . ." and that "under the analysis applied to a truly competitive market, appellant has failed to prove an illegal tying arrangement." However, the appellate court apparently determined that the traditional economic analysis was inapplicable to the health care industry. "The foregoing analysis assumes that the

[1] Horan and Nord, "Application of the Antitrust Laws to the Health Care Delivery System," 9 Cumberland Law Review 665 (1979).

health care industry functions as a competitive market in the same sense as the industries involved in the plethora of other tying cases and should be subject to the same standards (citations omitted). This is not correct. Several market imperfections in the health care industry favor public, non-profit entities like East Jefferson Hospital." 686 F.2d 286 at 290. The market imperfections the appellate court spoke of are: 1) the prevalence of third party reimbursement eliminating a patient's cost consciousness, 2) a lack of information regarding the quality of medical care, 3) a patient's belief that a non-profit hospital has no profit motive to cut quality; and 4) a patient's desire to go to a hospital closest to his home. 686 F.2d 286 at 290. The appellate court then concludes that the trial court incorrectly defined the relevant market and that the correct relevant market was the East Bank of Jefferson Parish. 686 F.2d 286 at 291. The appellate court went on to enumerate the anticompetitive effects of the exclusive contract as : 1) prevents market entry by other anesthesiologists and 2) eliminates the surgeon's or patient's choice of anesthesiologists at this hospital. Lastly, the appellate court rejected arguments against the application of *per se* rules to the health care industry based upon its reading of this Court's decision in *Arizona v. Maricopa County Medical Society*,____ U.S., ____, 102 S.Ct. 2466 (1982).

The *Amicus Curiae* Louisiana Hospital Association believes the appellate court erred on several points. First, we believe the trial court and the appellate court both erred in determining the existence of two separate and distinct services —surgical operating rooms (the tying product) and anesthesia service (the tied service). The *Amicus Curiae* Louisiana Hospital Association contends that the hospital offered but

one service — high quality in-patient hospital care. Modern acute care hospitals such as East Jefferson General Hospital, combine a myriad of services into a single packaged product. In today's hospitals, the patient is provided not only a bed and meals, but highly sophisticated ancillary services such as radiology, pathology, respiratory therapy, laboratory services, nursing services and others. These ancillary services are not separate but rather integral components of one product, i.e. in-patient hospital care. To take the reasoning of the lower courts one step further, hospitals engage in illegal tying arrangements every time they require a patient to use the hospital's ancillary services. The appellate court would have it so that the patient would rent the bed from the hospital and contract with independent contractors for all other services. The patient would have to: hire his own pharmacist to provide pharmaceutical services, his own nurse to provide nursing services, hire his own pathologist to perform and analyze all tests, hire his radiologist to perform and interpret his x-rays, hire his own physical therapist to administer physical therapy while he is a patient in the hospital, and so on. Furthermore, it would be impossible for the hospital to adequately monitor the quality of the services rendered under such an arrangement. All of these services which hospitals currently provide as part of the patient's in-hospital stay would have to be obtained by the patient from other sources with little if any means of monitoring quality. Hospitals are not merely hotels for the ill or injured, where physicians and other health care practitioners, operating as independent contractors, ply their services to patients. The *Amicus Curiae* Louisiana Hospital Association agrees with Horan and Nord[2] that "exclusive relationships between physicians and hospitals are analogous

[2] Id. p. 702

to agreements by manufacturers to limit the number and location of their distributors in a given geographic region. The primary impact of this limitation is on the manufacturer's sales activity, not that of the existing distributors." The hospital is akin to the manufacturer, in that in developing its marketing strategy it has chosen an exclusive arrangement as the method of providing twenty-four-hour availability of anesthesia services and enhancing the marketing of its emergency services. The latter point was supported by the testimony of Mr. Gagliano who stated that East Jefferson General Hospital has the second busiest emergency room in metropolitan New Orleans, second only to Charity Hospital of New Orleans, the state-owned hospital for the medically indigent (Tr., V.4, p. 187). Indeed, East Jefferson General Hospital's emergency room volume may be due in large part to the public's awareness that the hospital's ancillary services of anesthesia, radiology, patholgy and emergency medicine are available at a moment's notice twenty-four-hours a day. The *Amicus Curiae* Louisiana Hospital Association believes that such arrangements should be viewed in the same light as the vertical restriction at issue in *Continental T.V. Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 97 S.Ct. 2549, 53 L.Ed. 2d 568 (1977). In the instant case, East Jefferson General Hospital, in effect, granted Roux and Associates an exclusive distributorship for the provision of anesthesia services within its facilities. As pointed out by this Court in *Continental T.V., Inc. v. GTE Sylvania, Inc.* (ibid) vertical restrictions promote interbrand competition by allowing the manufacturer (here the hospital) to achieve certain efficiencies (see trial court's discussion of benefits of closed staff, 513 F.Supp. 532 at 540) in the distribution of his products. This Court noted that economists have identified a number of ways in which manufacturers can use

such restrictions to compete more effectively against other manufacturers. For example, new manufacturers and manufacturers entering new markets can use the restrictions in order to induce competent and aggressive retailers to make the kind of investment of capital and labor that is often required in the distribution of products unknown to the consumer. Established manufacturers can use them to induce retailers to engage in promotional activities or to provide service and/or repair facilities necessary to the efficient marketing of their products. Service and repair are vital for many products, such as automobiles and major household appliances. Their availability and quality of such services affect a manufacturer's good will and the competitiveness of his product. The correlation to East Jefferson's situation is striking. East Jefferson General Hospital was a new entrant into the hospital market in 1970. The testimony of two of the hospital's board of directors amply illustrates the correlation of East Jefferson to this Court's statements in *Continental T.V., Inc. v. GTE Sylvania, Inc.* (ibid).

"Q. Dr. Rourke, you mentioned when your advisory group was interviewing candidates for various posts at the East Jefferson Hospital during the period before the hospital opened that your group assumed and that these positions would be filled by exclusive contract personnel. And why did you assume that they would be?

"A. Well, for several reasons. First, we have to cast ourselves back into the situation we're in back in 1970. We had an empty building sticking up there in the sky in the middle of a drain swamp, which had never been a hospital before, and we had a new, untried, untested venture. And we had to build from scratch.

We were not overwhelmed with eager people looking for the various jobs in the hospital base specially.

"I know that this trial is about anesthesiologists, but in my own recollection of the period, we had four separate jobs to fill. Anesthesiology was one of them. And in two of the areas we had to really persuade people. Come on in and give us a try. It was an unopened book. We had no fiscal experience. They had to cast in their lot with us and take the chance that we would be a success. In anesthesia —Well, we felt that each department of the four departments only required one man to get it started. And even some of those men applicants were unsure whether they would be able to make a living at it. It was an untested venture. So, we were looking for one good man in each area to come in to cast — tie his future to ours, work with us and build a department.

"Does that answer —

"Q. I'm not sure it does, but if that's your answer, I will accept it.

"A. Well, I'll try and clarify it more.

"Q. I asked you why you assumed that you would have to have a contract anesthesiologist?

"A. Well, as an outgrowth of what I just said, we wanted one man who was going to ally himself with our hospital. And we felt that a contract would assure us that he would stay with us and also that it would — a contract would be our assurance to him that he was going to grow with us. (Tr. Vol. 4, pp 149-150)"

Dr. Rourke's testimony illustrates how East Jefferson General Hospital used a vertical restriction in order to induce

competent and aggressive anesthesiologists to make the kind of investment of capital and labor and take the risks required in the distribution of products unknown to the consumer.

Just as the availability and quality of such services (service and repair) affect a manufacturer's good will and competitiveness of his product, so does the availability and quality of a hospital's ancillary services affect the good will and effectiveness of a hospital's product. This concern is illustrated by the testimony of hospital board member Nicholas Gagliano.

"Q. Mr. Gagliano, relative to a question of open or closed staff or exclusive contract, does the hospital have a policy at this time with respect to the department of anesthesia?

"A. Yes. The hospital has had from the beginning and has from time to time reexamined and reaffirmed the position that the anesthesia department would best be served as a closed staff arrangement under contract.

The same situation exists with three to five other departments in the hospital. Now, principal reason that I have for it, I'm a layman, of course, to the medical profession. This is my first and only experience in the operation of a hospital, and therefore, I'm extremely cautious as to what I do and what decisions that I make on behalf of the hospital. I have to deal with the health and life of people that are going to depend on this institution for health care.

My major concern, and I think that of most of the laymembers of the board, is to assure that we have adequate total professional coverage around the clock. When I mean coverage, I mean that we want to be absolutely certain that if an emergency comes

> in at 2:00 o'clock in the morning, that we have an anesthesiologist there and ready and able to give any anesthesia. We want a pathologist there to run lab tests. We want a radiologist there to take the x-ray pictures. And that is the major concern as I see it from my point of view as a lay board member. And our judgment has been that we can best serve this with a contract which binds a group of doctors to be at our hospital all the time. (Tr. Vol. 4, pp 172-173)"

This *Amicus Curiae* respectively submits that such an exclusive agreement should be treated as a vertical restraint and should be subject to the rule of reason analysis pursuant to *Continental T.V., Inc. v. GTE Sylvania, Inc.*, (supra).

Assuming that the exclusive arrangement was in fact a tying arrangement, the appellate court erred in determining the relevant geographical market and in applying the appropriate standard. Although the appellate court correctly sets forth the appropriate test as contained in *U.S. Steel v. Fortner Enterprises*, 429 U.S. 610, 97 S.Ct. 861, 51 L.Ed. 2d 80 (1977):

> "whether the seller has the power, within the market for the tying product, to raise prices or to require purchasers to accept burdensome terms that could not be exacted in a completely competitive market. In short, the question is whether the seller has some advantage not shared by his competitors in the market for the tying product.
>
> Without any such advantage differentiating his product from that of his competitors, the seller's product does not have the kind of uniqueness considered relevant in prior tying-clause cases.

> Id. at 620-21, 97 S.Ct. at 867-68 (footnotes omitted), 686 F.2d at 290"

it failed to correctly apply that test. There was no evidence whatsoever that East Jefferson General raised prices. In fact, the appellate expressly found that the alleged tie-in did not result in a higher charge to the patient for anesthesia services. 686 F.2d at 291. Secondly, there was no evidence and the Fifth Circuit made no finding that East Jefferson General Hospital required patients to accept more burdensome terms within the market for operating rooms. There was no showing, and the Fifth Circuit made no determination, that East Jefferson General Hospital had some advantage not shared by its competitors in the market for operating rooms. Lastly, there was no showing, and the appellate court made no finding, that East Jefferson General's operating rooms were unique. The appellate court was unable to find any true market power on the part of East Jefferson under the traditional economic analysis. Therefore, the appellate Court boot strapped iteself into a *per se* violation by finding the health care industry to be an imperfect market and by redefining the geographical market area so as to exclude any hospitals on the East Bank of Orleans Parish from the geographical market. The Fifth Circuit ruled that the trial court erred in including the hospitals located on the East Bank of Orleans Parish within the geographical market for essentially three reasons: 1) the patient's preference for the hospital nearest his home, 2) the market imperfections inherent in the health industry that somehow favor public non-profit hospitals and 3) that because East Jefferson is a hospital service district its market area is limited by law to the East Bank of Jefferson Parish.

It is true that the third party payment system eliminates the patient's incentive to compare cost effectiveness of competing hospitals, however, all that means is that hospitals will not compete on the basis of price, but rather on the basis of quality and availability of services. *Robinson v. Magovern*, 521 F. Supp. 842 (1981) at p. 877. Furthermore, the absence of consumer cost consciousness benefits for-profit hospitals as much as non-profits. The appellate court determined in one breath that consumers were ignorant about quality of care and in the next breath assumed that consumers were informed as to the ownership status of the hospital, specifically, whether a hospital was non-profit or for-profit. It seems rather shortsighted to assume that a consumer's ignorance is limited to quality of care only and not the ownership status of a given hospital. Notwithstanding, the court theorizes that a patient believes that a non-profit hospital is less likely to cut quality than a for-profit one. However, the court ignores the fact pointed out in *Robinson v. Magovern* (ibid) that "When purchasing medical services, most consumer-patients look for high quality of care rather than for a low price" and therefore hospitals, non-profit and for-profit alike, strive to provide the highest quality of care possible. The appellate court then concludes that it is not surprising that these factors lead patients to select the hospital, in this case East Jefferson, closest to home. However, the appellate court's conclusion is contrary to the evidence which indicated that seventy percent of the patients residing on the East Bank of Jefferson Parish chose to go to hospitals in the Metropolitan area of New Orleans other than East Jefferson General Hospital. The trial court correctly held that the relevant geographical market area was composed of the hospital operating rooms in the East

Bank of Jefferson and Orleans Parishes because these were the alternate suppliers patients could practically turn to should East Jefferson General impose burdensome conditions or allow the quality or availability of its surgical facilities to deteriorate.

The appellate court seeks to bolster its determination that the East Bank of Jefferson Parish is the relevant geographical market by citing La. Revised Statute 46: 1055[3] which states in pertinent part that " . . . the commission shall have the duty and authority: 1) to represent the public interest in providing hospital and medical care in the district." The court's reliance on La. R.S. 46:1055 is unfounded for several reasons. First, the statute applies to the

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[3] § 1055. Powers and duties of commission

A. In addition to the duties defined elsewhere in this Chapter, the commission shall have the duty and authority:

(1) To represent the public interest in providing hospital and medical care in the district.

(2) To advise the police jury and the hospital director on problems concerning the operation of the hospital and other facilities.

(3) To make, alter, amend, and promulgate rules and regulations governing the conduct of the hospital.

(4) To conduct hearings and pass upon complaints by or against any officer or employee of the district.

(5) To review and modify, or set aside any action of the officers or employees of the district which the commission may determine to be desirable or necessary in the public interest.

(6) To appoint, with the approval of the medical staff, a director of the hospital and to perform such other duties as may now or hereafter be required by law.

(7) To appoint the necessary standing and special committees which may be necessary to carry out the purposes of this Chapter.

(8) To establish rates of pay for the use of facilities provided by the district.

(9) To enter into lease agreements with recognized and duly constituted nonprofit associations which are primarily engaged in the operation of hospitals.

B. In addition to the powers and duties set forth in Subsection A hereof, the commission may enter into a special services agreement with a hospital management firm or hospitals to manage, operate, and administer a hospital or hospitals, or any part thereof, under the control of the commission for the benefit of the hospital service district. The notice of intent to enter into a special services agreement shall be published in the official journal at least sixty days prior to the effective date of the contract.

Commission and not to the hospital. Secondly, hospital service districts are political subdivisions of the state. As such, they have the authority to expropriate property and to levy special maintenance taxes, La. R.S. 46:1064.[4] However, this authority is limited to the territorial boundaries of the district and La. R.S. 46:1051[5] requires the police jury creating the district to establish its boundaries. So the language in La. R.S. 46:1055 should not be viewed as a definition or restriction on a hospital's market but rather as a restriction on the expropriating and taxing power of the hospital service district. Therefore, Jefferson Parish Hospital Service District Number Two may market its hospital services to persons residing in Orleans Parish but it may not expropriate or levy a tax on property located in Orleans Parish. In essence, the appellate court determined the relevant market to be East Jefferson Hospital itself and this is clearly erroneous.

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[4] **§ 1064. Districts as political subdivisions; acquisition of land and physical facilities; special maintenance taxes; incurring debt; bonds**

The hospital service districts created under the provisions of this chapter are hereby declared to be political subdivisions of the state, and for the purpose of purchasing and acquiring lands and purchasing, acquiring, constructing and maintaining hospials, nurses homes, physicians and dentists offices, laboratories, and other physical facilities necessary to carry out the purposes of this chapter. Title to such land and physical facilities shall be in the public. Such districts shall be subdivisions of the State of Louisiana within the meaning of the laws of Louisiana relating to the voting and levy of special maintenance taxes incurring debt and issuing bonds therefor, including particularly but without limitation. Revised Statutes Title 39, Sections 501-518; 551-571; 575-577; 617; 701-706; 911.

[5] **§ 1051. Authority to create and alter the boundaries of districts**

The police juries of parishes are authorized and empowered, upon their own initiative, to form and create one or more hospital service districts within the respective parishes, or with agreement among police juries concerned, to combine two or more parishes into a single hospital service district with such names as the police juries may designate, and, in so doing, police juries may create hospital service districts whose boundaries overlap those of other hospital service districts.

The police juries are further authorized and empowered, upon their own initiative, to alter the boundaries of any hospital service district, provided that no such boundary change shall cause an impairment of the obligations of any contract of the hospital service district.

Such creation of overlapping hospital service districts or the alteration of the boundaries of any hospital service district prior to July 31, 1968, are hereby expressly validated, ratified and confirmed.

The appellate court enumerates the anti-competitive effects of the exclusive contract as being 1) preventing anesthesiologists from entering that part of the anesthesia service market which the hospital controls, lowers quality while increasing hospital profits and 2) eliminates the surgeon's or patient's choice of anesthesiologists at the hospital, which the court found to be economic coercion. 686 F.2d 286 at 290. The appellate court's phraseology is enlightening for it reveals that the court has, in fact, determined the relevant market to be East Jefferson General Hospital, and this conflicts with the Seventh Circuit's doubts that a relevant market can be sliced so small as to embrace only one hospital. *Dos Santos v. Columbus Cuneo-Cabrini Medical Center*, 684 F.2d 1346 (1982) at 1353. The Fifth Circuit's phraseology might be proper if East Jefferson General were the only hospital in the area, but it is not, for both the trial and appellate courts admitted there were twenty hospitals in the area.

The purported anti-competitive effects are not as they appear. First, market entry is not precluded. Nothing prevents an anesthesiologist from competing with Roux and Associates for East Jefferson General's exclusive contract. In fact, Dr. Hyde did just that when the hospital began its operations (Tr. Vol. 4, pp 195-196). The appellate court's language about denial of patient or surgeon choice is not substantiated. In *U.S. v. American Society of Anesthesiologists*, 473 F.Supp. 147 at 160, it was stated:

> "Anesthesiologists rarely have contact with patients prior to their surgery and the evidence suggests that fees are almost never discussed. In fact, patients have little input into the selection of their anesthesiologists and third party carriers pay over ninety percent of an-

esthesiologists fees. There is no evidence of competition between anesthesiologists insofar as patients are con-concerned, in fact, there is unrefuted evidence that the patient is not truly a customer of the anesthesiologist. (See also *Dos Santos v. Columbus-Cuneo-Cabrini*, 864 F.2d 1346 (1982) at 1354.)

From the above it can be determined that the appellate court erred in declaring the exclusive anesthesia contract a *per se* illegal tying arrangement under Section I of the Sherman Act 15 U.S.C. 1 (1976). It erred by its failure to show that East Jefferson General 1) was able to raise prices or, 2) able to require purchasers to accept burdensome terms that could not be exacted in a completely competitive market or, 3) that it had some advantage not shared by competing hospitals in the market for operating rooms or, 4) that its operating rooms were unique.

CONCLUSION

This court has let it be known that the medical profession and the health industry will be subject to *per se* antitrust analysis. *Arizona v. Maricopa County Medical Society*, ____ U.S. ____, 102 S.Ct. 2466 (1982). However, it should be stressed that the Court in *Maricopa* was faced with a maximum price-fixing arrangement which is unquestionably the most naked form of restraint of trade. In the instant case, the Court must decide whether an exclusive anesthesia contract is a tying arrangement and, if so, whether it met the test of *per se* illegality articulated in *U.S. Steel v. Fortner Enterprises*, 429 U.S. 610 97 S.Ct. 861, 51 L.Ed. 2d 80 (1977). The Fifth Circuit determined that the contract in question met the requirements for *per se* illegality. *Amicus Curiae* Louisiana Hospital Association believes the appellate court erred in doing so. If it did not, *Amicus Curiae* Louisiana Hospital Association respectfully suggests that this Court reconsider the *per se* approach to tying arrangements. See Freed, Charles; "Reconsidering the Per Se Approach to Tying Arrangements," 13 Toledo Law Review 571-586 (Spring 1982).

CERTIFICATE OF SERVICE

I hereby certify that I have this _____ day of April, 1983 served copies of the attached Brief *Amicus Curiae* of the Louisiana Hospital Association by sending three copies thereof by first class mail, postage prepaid, to each of the following:

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NO. 82-1031

In the Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2
and EAST JEFFERSON HOSPITAL BOARD,

PETITIONERS

versus

DR. EDWIN G. HYDE,

RESPONDENT

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

AMICUS CURIAE BRIEF
ON BEHALF OF THE RESPONDENT

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QUESTIONS PRESENTED

1.

Whether an exclusive contract between a public hospital and an independent professional corporation of anesthesiologists which establishes a closed shop as to outside anesthesiologists and which compels users of the hospital's surgical facilities to retain the anesthesia services of the corporation *CREATES A TYING ARRANGEMENT THAT IS ILLEGAL PER SE UNDER THE SHERMAN ANTITRUST ACT.*

2.

Whether an exclusive agreement between an independent professional corporation of anesthesiologists and a public hospital which compels users of the hospital's surgical facilities to retain the anesthesia services of the corporation and which establishes a closed shop as to outside anesthesiologists, *CREATES AN "UNREASONABLE" RESTRAINT OF TRADE.*

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ON BEHALF OF THE RESPONDENTS

JURISDICTIONAL STATEMENT

The judgment of the court of appeals was entered on September 20, 1982. The petition for a writ of certiorari was filed on December 17, 1982, and granted on March 7, 1983. The jurisdiction of this Court rests on 28 U.S.C. § 1254(1).

INTEREST OF THE AMICUS CURIAE

The Louisiana State Medical Society, as amicus curiae, files this brief in support of the position submitted

by Dr. Edwin Hyde. A similar action was taken by this amicus curiae in this matter when it was before the United States Court of Appeals for the Fifth Circuit. This amicus curiae strongly believes in the principles of free competition for all of the members of the Society and all doctors everywhere. Under the circumstances before the Court, the competitive interests of the members of the Society as well as other health care providers have been severely restrained by the exclusive contract and closed shop atmosphere between the public hospital and the independent professional corporation of anesthesiologists.

STATEMENT OF THE CASE

On July 14, 1977, Dr. Edwin G. Hyde submitted an application for medical staff privileges in the Department of Anesthesiology at East Jefferson General Hospital. (This medical facility was built with public funds from both the state and federal government.) As Dr. Hyde's application weaved its way through the bureaucratic process, it was approved at every level including an affirmative finding by the medical staff. However, when the application reached the final level on October 18, 1977, it was rejected by the Board of Directors of the hospital. Dr. Hyde received notice of the Board's decision by letter which indicated that his application had been rejected because of the exclusive nature of a contract in existence between the hospital and a group of anesthesiologists known as Roux & Associates. Under this contract, a "closed shop" was in effect at the hospital, that is, an anesthesiologist who was not a member of the group of Roux & Associates was not permitted to contract with the hospital to provide anesthesiological services. Though a physician such as Dr. Hyde had qualifications equal to those members of Roux & Associates, he was not allowed to practice his profession

simply because of this exclusive contract with the anesthesiological group.

As a result of the foregoing circumstances, an action was brought by the respondent, Dr. Edwin Hyde, for declaratory and injunctive relief against the hospital regarding his exclusion from the medical staff at the hospital. Dr. Hyde requested the district court to declare that his exclusion from the medical staff was illegal. The respondent's primary basis for this action was his contention that Section 1 of the Sherman Antitrust Act was violated. Dr. Hyde contended that the Sherman Act had been violated as there was a per se illegal tying arrangement in that users of the hospital's surgical facilities (the tying product) were compelled to purchase anesthesia services (the tied product) from Roux & Associates. Furthermore, Dr. Hyde contended that there were unreasonable restraints of trade present as a result of this exclusive contractual arrangement. Additionally, Dr. Hyde sought issuance of an injunction requiring the defendants to appoint him to the medical staff of East Jefferson Hospital.

Upon trial of this matter, the district court entered judgment dismissing the claim brought by Dr. Hyde. See *Hyde v. Jefferson Parish Hospital District No. 2*, 513 F.Supp. 532 (E.D. La. 1981). On appeal, the United States Fifth Circuit reversed the district court's judgment and found that there was a violation of Section 1 of the Sherman Act as the exclusive contract between Roux & Associates and the hospital created a tying arrangement that was illegal per se. See *Hyde v. Jefferson Parish Hospital District No. 2*, 686 F.2d 286 (5th Cir. 1982).

The amicus curiae adopts the remainder of the statement of the case of the respondent as per Rule 36.5 of the

Rules of the United States Supreme Court.

SUMMARY OF THE ARGUMENT

A. The East Jefferson General Hospital is a public hospital as it was built with public tax dollars and as such, it should be open to all citizens whether they be patients or physicians. Considering the public nature of the hospital, any form of a closed shop would clearly be an unreasonable restraint of trade. Aside from the general consideration of the preservation of competition, an equally important concern should be the quality of health care that is provided to the respective patients of the hospital. The decline in health care which results from the exclusive contract arrangement is one of the anti-competitive effects of the exclusive contract arrangement between the hospital and the anesthesiological group.

B. The exclusive contract arrangement between the hospital and the anesthesiological group is a tying arrangement that is illegal per se. There are two separate products involved in this matter, with the hospital's surgical facilities as the tying product and the anesthesia services as the tied product. The relevant geographical market for consideration is the Eastbank of Jefferson Parish. The market power possessed by East Jefferson Hospital is clearly sufficient to coerce the purchase of anesthesia services by perspective patients which is reflected by the power of the medical facility to raise prices and otherwise impose burdensome terms. The arrangement with which we are concerned affects a substantial amount of interstate commerce as it involves the use of federal funds, supplies from out of state manufacturers and treatment to out of state patients. The illegal tying arrangement creates numerous anti-competitive effects including the preclusion

of other anesthesiologists from practicing at a public hospital, the denial of the freedom of choice of a patient or surgeon to select an anesthesiologist, the imposition of artificial prices, and a decline in the quality of health care.

C. Professional services are subject to Sherman Act scrutiny so long as the particular activity involves business or economic concerns. The tying arrangement in this matter can only be regarded as business oriented or economical in nature.

D. Under the rule of reason we must consider whether the restraint involved merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition. There are numerous anti-competitive effects which result from the exclusive contract between the hospital and the anesthesiological group which create an unreasonable restraint on competition for anesthesiological services.

ARGUMENT

A. *POLICY STATEMENT:*

A discussion of the purpose of the Sherman Act was stated by this Honorable Court in *Northern Pacific Railway Company v. United States,* 356 U.S. 1, 2 L.Ed.2d 545, 78 S.Ct. 514 (1958). This Court stated:

> The Sherman Act was designed to be a comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade. It rests on the premise that the unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality

> and the greatest material progress, while at the same time providing an environment conducive to the preservation of our democratic political and social institutions. But even were that premise open to question, the policy unequivocally laid down by this Act is competition. And to this end it prohibits, "every contract, combination... or conspiracy, in restraint of trade or commerce among the several states." 356 U.S. at p. 4.

The East Jefferson General Hospital is a public hospital as it was built with public funds from both the state and federal government. As such, all citizens should have the opportunity to use this facility and select their physicians whether they be cardiologists, neurologists, anesthesiologists or any other independent provider of health care. Moreover, any qualified physician should have the opportunity to use such a public facility regardless of the political ties that he or she may have with the authority operating the hospital. Anything short of an open shop is clearly an unreasonable restraint on competition and a threat to the "highest quality" of medical care. To permit the present situation at East Jefferson General Hospital to continue would violate the fundamental goals and ideals set forth by the Sherman Act. Furthermore, to permit the use of a public hospital built with public tax dollars by a limited and chosen few creates an environment which is not "conducive to the preservation of our democratic, political and social institutions."

Aside from the broader considerations of the preservation of competition, is the equally important concern for the quality of the health care that is provided to the respective patients of the hospital. It is clear that the exclusionary contract in effect at East Jefferson has a direct bearing on the physical well-being of the patients of the

hospital, including situations which involve life and death. The concern is the easily distinguishable converse of the numerous antitrust cases which involve automobile motors and tires, razors and blades, chicken franchises and accessories, computors and computor cards, salt and salt dispensers, and the like.[1] Careful scrutiny should be given to cases which involve health care just as special scrutiny is given to certain classes under the Equal Protection Clause of the 14 Amendment. The evidence shows a clear anti-competitive effect on the quality of health care at East Jefferson General Hospital. It is significantly reduced because of the exclusive contract agreement between the public hospital and the independent professional corporation of anesthesiologists.

The effect of permitting the anti-competitive restraints imposed by the exclusionary contract is to legitimize steps toward a total elimination of the freedom of choice by a patient as to health care. Under the present circumstances, wherein a typical hospital has an exclusive agreement with a group of physicians for each department, the patient has no choice as to who will administer treatment to him.[2] In effect, the only freedom of choice that remains is the selection of a hospital, a choice often dictated by the primary physician treating the patient. Upon making such a selection, the hospital dictates all aspects of an individual's health care, including his selection of additional independent physicians. The result is that the

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[1] See *Siegel v. Chicken Delight*, 448 F.2d 43 (9th Cir. 1971); *International Business Machines Corporation v. United States*, 291 U.S. 131 (1936); *International Salt Company v. United States*, 332 U.S. 392 (1947); *United States v. Jerald Electronics Corporation*, 187 F.Supp. 545 (E.D. Penn. 1960), *aff'd procuriam*, 365 U.S. 567 (1961).

[2] Both lower courts made specific reference that exclusive contracts exist for almost all medical departments in an average hospital.

hospital escapes responsibility for the selection of the anesthesiologist, but retains economic and managerial control through a tied contract. Ultimately the patient must forego the selection of his physicians to obtain the services of his selected hospital or the one which his primary physician practices.

B. *THE EXCLUSIVE CONTRACT IS A TYING ARRANGEMENT THAT IS ILLEGAL PER SE*

Section 1 of the Sherman Act (15 U.S. § 1) declares that "every contract, combination, ... or conspiracy in restraint of trade among the several states ... is hereby declared to be illegal." Certain agreements or practices which because of their pernicious effect on competition and lack of redeeming virtue have been deemed illegal per se. *Northern Pacific Railway Company v. U.S.*, 356 U.S. 1, 5, 78 S.Ct. 514, 518 (1958). Under Section 1 of the Sherman Act, tying arrangements are illegal per se whenever the appropriate factors or requirements are satisfied. A tying arrangement is an agreement by a party to sell one product but only on the condition that the buyer also purchases a different or tied product or at least agrees that he will not purchase the product from any other supplier. See: *Northern Pacific Railway Company, supra.*

There are certain requirements that must be considered when determining whether a tying arrangement is illegal. These characteristics are:

1. Two separate products, the tying product and the tied product;

2. Sufficient market power in the tying market to coerce purchase of the tied product;

3. Involvement of a not insubstantial amount of interstate commerce in the tied market; and

4. Anti-competitive effects in the tied market.

See, *Maxfield, Inc. v. American Motors Corp.*, 637 F.2d 1033 (5th Cir. 1981); *Bogus v. American Speech & Hearing Association*, 582 F.2d 277 (3rd Cir. 1978); *Driskell v. Dallas Cowboys' Football Club*, 498 F.2d 321 (5th Cir. 1974). Other courts have required only the first three requirements listed above. See, *Siegel v. Chicken Delight, Inc.*, 448 F.2d 43 (9th Cir. 1971). If all of these characteristics are satisfied then the tying arrangement is illegal per se without showing an unreasonable restraint of trade. *International Salt Company v. United States*, 332 U.S. 392, 92 L.Ed. 20 (1947); *Hirsch v. Martindale Hubble*, 674 F.2d 1343 (9th Cir. 1982). Moreover, if a plaintiff satisfies these requirements then there is no "necessity for an incredibly complicated and prolonged economic investigation into the entire history of the industry involved, as well as related industries, in an effort to determine at large whether a particular restraint has been unreasonable —an inquiry so often wholly fruitless when undertaken." *Northern Pacific Railway Company v. U.S.*, 356 U.S. 1, 5, 78 S.Ct. 514, 518 (1958).

The primary purpose for regarding certain tying arrangements as illegal per se was succinctly stated in *Siegel v. Chicken Delight, Inc.*, 448 F.2d 43 (9th Cir. 1970). The Court stated:

> The hallmark of a tie-in is that it denies competitors free access to the tied product market, not because the party imposing the arrangement has a superior product in that market, but because of the power or leverage exerted by the

tying product. Rules governing the tying arrangements are designed to strike, not at the mere coupling of physically separable objects, but rather at the use of a dominant desired product to compel the purchse of a second, distinct commodity. *Times-Picayune Publishing Company v. United States*, 345 U.S. 614, 73 S.Ct. 872, 97 L.Ed. 1277. In effect, the forced purchse of the second, tied product is a price exacted for the purchase of the dominant, tying product. By shedding competitors out of the tied product market, tying arrangements serve hardly any purpose other than the suppression of competition. *Standard Oil Company v. United States*, 337 U.S. 293, 69 S.Ct. 1051, 93 L.Ed. 1371 (1949). 448 F.2d at p. 47.

In *Arizona v. Maricopa County Medical Society*, 102 S.Ct. 2466, 73 L.Ed.2d 48 (1982), this Honorable Court indicated that the rules of per se illegality are applicable to the health care industry. Any argument to the contrary is unfounded.

1. *THE PRESENCE OF TWO SEPARATE PRODUCTS:*

At the outset of every tying case, there is the problem of determining whether two products are in fact involved. *Fortner Enterprises, Inc. v. United States Steel Corporation*, 394 U.S. 495, 507, 89 S.Ct. 1252, 1260, 22 L.Ed. 495 (Fortner 1). In determining whether an aggregation of items constitutes one or more products for antitrust purposes, we must look to the function of the aggregation. *Hirsch v. Martindale Hubble, Inc.*, 674 F.2d 1343 (9th Cir. 1982). This necessarily requires an inquiry into the nature of the relationship between the alleged tying product and the alleged tied product. See *Krehl v. Baskin-Robbins Ice*

Cream Company, 664 F.2d 1348, 1353.

In the matter before the Court, it is indisputable that not only one, but two tying arrangements were established by the exclusive contract entered into by Roux & Associates and the hospital. The first tying arrangement is that as a condition for the use of the hospital's surgical facilities (the tying product), a patient is compelled to agree to purchase the anesthesia services of Roux & Associates (the tied product). A second tying arrangement exists in that as a condition for the provision of anesthesia services by a member of Roux & Associates (the tying product), a person is compelled to agree to use and pay for the provision of the hospital's surgical facility (the tied product). It is these tying arrangements established by the contract which has injured the respondent and which affects the amicus curiae by restraining competition between its members.

It is clear that there are two separate products here. The director of the hospital testified that approximately 875 operations are performed on a monthly basis or about 10,00 surgieries per year. (R-513 F.S. at 538). In each case, a separate fee is charged for the anesthesia services that are provided during these surgeries, apart from the fees that are charged for the use of the hospital's surgical facilities.[3]

Therefore, it is clear that two separate products are present, one in the form of anesthesia services, and the

[3] If we were to view these circumstances from a financial standpoint, then we should consider that it is likely that gross fees in excess of $1,000,000 are collected by the hospital on an annual basis for the anesthesiological services made available by the hospital to its perspective patients. This figure is reached if we consider that a minimum of $100 in fees is charged for anesthesiological services associated with each surgery.

other in the form of surgical facilities. Additionally, these products are furnished by two completely different entities, Roux & Associates and the hospital, respectively.

2. *SUFFICIENT MARKET POWER*

a) *THE APPROPRIATE GEOGRAPHIC MARKET*

The second requirement which must be satisfied in order to establish a tying arrangement that is illegal per se is that the seller must possess sufficient economic power in the market of the tying product to coerce purchase of the tied product. *Northern Pacific Railway Company v. United States*, 356 U.S. 1, 6, 78 S.Ct. 514, 518, 2 L.Ed.2d 545 (1958). The first determination that must be made with respect to this requirement is the relevant geographic market.

In reviewing the opinions of the lower courts, it is clear that there is a disagreement as to the relevant geographic market.[4] The district court's finding regarding the relevant geographic market was as follows:

> A relevant geographic market is the market in which the seller operates and to which the purchaser can practically turn for supplies. The evidence showed that 70% of the patients from the Eastbank of Jefferson Parish go to hospitals in the Metropolitan-New Orleans area other than

[4] The Metropolitan-New Orleans area consists of three parishes (counties) including Orleans, Jefferson and St. Bernard. Jefferson Parish is divided into what is commonly referred to as the Eastbank, which represents all citizens who reside in the parish on the eastern side of the Mississippi River, and the Westbank, which represents all citizens who reside in the parish on the western side of the Mississippi River. East Jefferson Hospital is located on the Eastbank of Jefferson Parish.

> East Jefferson. The data presented by the New Orleans area Bayou-River Parish system shows large numbers of Jefferson residents go to hospitals in the New Orleans area such as Mercy, Baptist and Touro Hospitals and Hotel Dieu. Therefore, plaintiff must show that East Jefferson dominated the market which at least includes the Orleans Parish hospitals which are located on the Eastbank. (R-Record on Appeal, Vol. II, at 246-247).

The district court in making such a conclusion, failed to make the crucial determination it had set out to do. To repeat again, the court was required to determine the geographic market in which the hospital competes for the provision of surgical facilities (the tying product). The data which showed that 70% of the patients from the Eastbank of Jefferson Parish go to hospitals in the Metropolitan-Orleans area other than East Jefferson was incomplete because at various times certain hospitals did not participate in the surveys. (R-513 F.S. at 539). Additionally, and more importantly, there was no information with regard to which patients had surgery. It is inconceivable to imagine how the district court concluded that the relevant geographic market in which the hospital competes for the provision of surgical facilities was the Metropolitan-Orleans area based upon the evidence presented.

As an example, one could state that while 70% of the residents of the Eastbank of Jefferson Parish go to Metropolitan-Orleans area hospitals other than East Jefferson, not one out of that group did so for the purpose of using the surgical facilities. To phrase this another way, only 30% of the residents of Eastbank of Jefferson Parish are in need of surgical facilities, and all of them go to East Jefferson Hospital.

While the above example is extreme, it merely points out the error made by the district court in failing to keep in mind the specific product (surgical facilities), so crucial to any market definition in antitrust analysis.

To the contrary, the Court of Appeal determined that the relevant geographic market was the Eastbank of Jefferson Parish. (R-686 F.2d at 291). We believe that this determination is the accurate one for several reasons. The plain and simple truth here is that the majority of potential patients chose a hospital that is closest to their home. Even the district court recognized this fact when it stated:

> It is likely that any individual will chose to go to a hospital closest to his home if it is possible to do so for the convenience of the family. Persons living nearer to hospitals in other areas will chose to go to these hospitals if possible. (R-Record on Appeal, Vol. II, at 247-248).

A second reason here is that patients do not chose a hospital based on the price of the services. This is due in part to the fact that the large majority of hospital bills are paid by third-party insurers. (R-686 F.2d at 290). Moreover, price lists for services are not readily available for the consumer to scrutinize. A third reason is that one-third of all of the patients from the East Jefferson area go to East Jefferson Hospital, the only public hospital on the Eastbank of Jefferson Parish. (R-686 F.2d at 291). Finally, the hospital is operated by a "hospital service district" pursuant to LSA-R.S. 46:1051, *et seq.* The district which the hospital serves includes only the Eastbank of Jefferson Parish. The hospital board is directed by LSA-R.S. 46:1055 "to represent the public interest in providing hospital and medical care *in the district.*" Thus, by law, the hospital's

primary purpose is to serve the residents of the Eastbank of Jefferson Parish. Although the hospital may, by necessity or by choice, also treat residents of other areas, its primary market area is limited by law to the Eastbank of Jefferson Parish.

Based on the foregoing, we urge this Court to view the relevant geographic market as the Eastbank of Jefferson Parish as opposed to the Metropolitan-New Orleans area. The overall facts abundantly support this finding as discussed above.

b) *ACTUAL MARKET POWER*

The second consideration with regard to this requirement for an illegal tying arrangement is whether the market power possessed by East Jefferson Hospital is sufficient to coerce the purchase of the tied product. In *Fortner Enterprises, Inc. v. United States Steel Corporation*, 394 U.S. 495, 502, 89 S.Ct. 1252, 22 L.Ed. 495 (1969), this Court discussed the showing of sufficient economic power as follows:

> "A standard of sufficient economic power does not, as the district court held, require that the defendant have a monopoly or even a dominant position throughout the market for the tying product. Our tying cases have made unmistakeably clear that the economic power over the tying product *can be sufficient even though the power falls far short of the dominance and even though the power exists only with respect to some of the buyers in the market.*
>
> ...
>
> Accordingly, the proper focus of concern is whether the seller has the power to raise prices,

> or impose other burdensome terms such as a tie-in, with respect to any appreciable numbers of buyers within the market."

This position was followed by this Court in *U.S. Steel Corporation v. Fortner Enterprises, Inc.*, 429 U.S. 610 (1977)-Fortner II.

Because a significant number of surgical patients in the hospital's geographic area will select East Jefferson Hospital without regard to price or at the direction of their surgeon, the hospital anesthesiological group is free to impose prices free of competitive restraints. The result extinguishes competition in both cost and quality. This result is clearly demonstrated by the fact that patients at East Jefferson pay anesthesia fees based on the fee rate of anesthesiologists although most of the work is performed by nurse anesthetists. (R-686 F.2d at 291). Based on the foregoing, we submit that the standard (Fortner 1) set forth for this requirement has been satisfied as the hospital has the power to impose burdensome terms and raise prices, and further that this has taken place under the exclusive contract.

3. *INVOLVEMENT OF A NOT INSUBSTANTIAL AMOUNT IN INTERSTATE COMMERCE*

In *U.S. v. Frankfort Distillers*, 324 U.S. 293, 297, 89 L.Ed. 951 (1945), this Court discussed the third requirement necessary to establish a tying arrangement as illegal per se. Recall that this requirement is that the tying arrangement must involve a not insubstantial amount of interstate commerce in the tying market. In *U.S. v. Frankfort Distillers, supra*, the Court stated: "There is an

obvious distinction to be drawn between a course of conduct wholly within a state and conduct which is an inseparable element of a larger program dependent for its success upon activity which affects commerce between the states." Hence, the tying arrangement must affect commerce among the states.

In *Goldfarb v. Virginia State Bar Association*, 421 U.S. 773, 44 L.Ed.2d 572 (1975), a challenge was brought by the claimant as to the minimum fee schedules set by the bar association and adhered to by practitioners concerning title searches in connection with the purchase of real estate. The claimant submitted that this practice was a violation of the Sherman Act. When considering the third requirement for establishing an illegal tying arrangement per se, the Court held that the effect of this practice on interstate commerce was substantial as many of the loans for the purchse of homes involved funds from federal agenceis such as the Veterans Administration and Housing and Urban Development.

In the case before the Court, it is overwhelmingly clear that a substantial amount of interstate commerce is affected by the tying arrangement between the hospital's surgical facilities and the anesthesia services. The evidence establishes that:

1. Anesthesia medicines and other surgical supplies are purchased from out of state suppliers;

2. Many of the patients' bills for anesthesia services and hospital care are paid by federal medicare and medicaid benefits as well as foreign insurance companies; and

3. A significant percentage of the patients who

require anesthesia services and hospital care are from out of state. (R-513) F.S. at 540).

Both of the lower courts were in agreement that this requirement was satisfied.

4. *ANTI-COMPETITIVE EFFECTS IN THE TIED MARKET*

The final requirement for establishing an illegal tying arrangement concerns the existence of anti-competitive effects in the tied market. We contend that there are numerous anti-competitive effects which overwhelmingly indicate that this last factor has been satisfied.

Initially, the exclusive contract between the hospital and Roux & Associates precludes any other anesthesiologist in the New Orleans area or for that matter in the country from practicing his profession at a public hospital that was built with taxpayer dollars. The reverse of this point is that only four anesthesiologists are permitted to practice this branch of medicine at the hospital. Hence, the freedom of choice of an anesthesiologist outside of the group to practice in a public hospital is denied. This is a significant restraint upon the rights of those who practice this profession.

The net effect of this closed shop arrangement is to create a lack of competition within the hospital which will discourage the anesthesiological group with the exclusive contract from improving or initiating new techniques and procedure. (R-513 F.S. at 539). This was the view of Dr. John Andriani, who is a practicing anesthesiologist of some 40 years, and who testified at trial. Dr. Andriani further testified that this closed system

discourages anesthesiologists from coming to New Orleans and medical students from entering the field because of a lack of positions in the area. (R-513 F.S. at 539). Additionally, there was other testimony at trial that this arrangement caused the hospital to hire nurse anesthetists in place of much needed anesthesiologists, which practice dilutes the quality of professional care available to the public. This is evident by the testimony of the director of the operating rooms at the hospital, Mrs. Melvaize Tedeschi, who stated that on the average day there are twelve to thirteen operating rooms in use at one time and only the four physician members of the anesthesiological group working them. (R-513 F.S. at 538).

An additional anti-competitive effect of this tying arrangement is that the patient who is in need of the hospital surgical facilities, has no choice as to the anesthesiologist who will assist in the operation. Moreover, the surgeon performing the operation is faced with the same position in not having a choice as to the anesthesiologist who he will be working with during the surgery. Dr. Charles Eckert, an anesthesiologist in the group of Roux & Associates, testified that a patient should be given the right to choose his anesthesiologist. (R-513 F.S. at 537). Dr. Eckert further testified that his group has been criticized by their peers for acting unethically due to the existing exclusive arrangement.

Another anti-competitive effect here is the artificial price that is charged to most patients for anesthesia services. The evidence presented reflects that many patients are billed for the anesthesia services of an anesthesiologist, when a nurse anesthetist is likely to have performed most of the work associated with the surgery. (R-686 F.2d at 291). In many instances, an anesthesiologist may have had

very little involvement in the operation.

The most important anti-competitive effect of the tying arrangement is the affect on health care. Both Drs. Roux and Eckert testified that they practiced their profession at other hospitals in the New Orleans area. (R-513 F.S. at 537). Not only is this action a violation of the exclusive contract between the anesthesiological group and hospital, but it must have a detrimental effect on the quality of anesthesia services received by the patients in the use of the hospital's surgical facilities. This is supported by the statement of Mrs. Melvaize Tedeschi, the director of the operating rooms at East Jefferson General Hospital, who stated that there are twelve or thirteen operating rooms in use at any one time. (R-513 F.S. at 538). Hence, if some of the anesthesiologists are practicing at other hospitals then it is quite likely that there is a lack of the appropriate professional anesthesiological skills available during surgery in the numerous operating rooms at the hospital. In many instances, the nurse anesthetists perform the majority of the anesthesia services during any particular surgery. (R-686 F.2d at 291). The record reveals that nurse anesthetists have no more than two years of training before they are able to practice; whereas, an anesthesiologist has four or five times the number of years of training. Finally the lack of competition created by this exclusive contract, discourages the anesthesiological group from improving or initiating new techniques and procedures which has a direct bearing on the quality of the health care at the hospital.

The evidence overwhelmingly demonstrates that the tying arrangement between the hospital and the anesthesiological group is illegal per se as all four requirements are easily satisfied.

C. *PROFESSIONAL SERVICES SUBJECT TO SHERMAN ACT SCRUTINY*

In the course of antitrust law, in many legal circles it was believed that professions were exempt from the Sherman Act. However, in *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 44 L.Ed.2d 572, 95 S.Ct. 2004 (1975), this Court indicated that indeed professions would be subject to Sherman Act scrutiny. The Court stated:

> We cannot find support for the proposition that Congress intended any such sweeping exclusion. The nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act, nor is the public service aspect of professional practice controlling in determining whether Section 1 precludes professions. *United States v. National Association of Real Estate Board*, 339 U.S. 400, 94 L.Ed. 1070, 70 S.Ct. 711. Congress intended to strike as broadly as it could in Section 1 of the Sherman Act, and to read into it so wide an exemption as that urged on us would be at odds with that purpose.

However, this Court indicated that an exception was available to professions from coverage under the Sherman Act. (See footnote 17 at p. 787). This exception is based on the distinction between the business or economic aspects and professional service aspects of the particular activity, the former being subject to Sherman Act's scrutiny and the latter not. This view was further clarified by the Seventh Circuit in *Williams v. St. Joseph Hospital*, 629 F.2d 448 (7th Cir. 1980), where the Court stated:

> We are satisfied also that professional services are subject to the antitrust laws. Though the Supreme Court avoided that question in

> *American Medical Association v. U.S.*, 317 U.S. 519, 528, 63 S.Ct. 326, 328, 87 L.Ed. 434 (1943), later cases indicate plainly that with regard to its economic aspects professional activity is subject to the policies of the antitrust laws. *Bates v. State Bar of Arizona*, 433 U.S. 350, 356, 363, 368-72, 97 S.Ct. 2691, 53 L.Ed.2d 810 (1977).

In this matter, the activity by which we are concerned is business in nature. As we discussed previously, the fee for anesthesiological services in a particular year is most likely in excess of $1,000,000. This does not take into consideration the separate fees that are generated by the hospital surgical facilities. Hence, this activity can only be regarded as business oriented or economical in nature.

D. *CONTRACT AS AN UNREASONABLE RESTRAINT OF TRADE*

The jurisprudence interpreting the Sherman Act indicates that even if a complainant fails to meet the standards of per se illegality, he may prevail by proving that the contract unreasonably restrains competition in violation of the more general standards of the act. *Bogus v. American Speech and Hearing Association*, 582 F.2d 277, 287 (3rd Cir. 1978); *Fortner v. U.S. Steel*, 394 U.S. 495, 22 L.Ed.2d 495 (1969). The test to be implied was clearly stated by this Court in *National Society of Professional Engineers v. United States*, 435 U.S. 679, 98 S.Ct. 1335 (1978), wherein the court stated:

> The test prescribed in Standard Oil is whether the challenged contracts or acts "were unreasonably restrictive of competitive conditions." Unreasonableness under that test could be based either (1) on the nature or character of the contract, or (2)

on surrounding circumstances giving rise to the inference or presumption that they were intended to restrain trade and enhance prices. Under either branch of the test, the *inquiry is confined to a consideration of the impact on competitive conditions.*

In this respect the Rule of Reason has remained faithful to its origins. From Justice Brandeis' opinion for the Court in Chicago Board of Trade, supra, the Court has adhered to the position that the inquiry mandated by the Rule of Reason is whether the challenged agreement is one that promotes competition or one that suppresses competition. "*The true test of legality is whether the restraint imposed is such as merely regulates and perhaps thereby promotes competition or whether it is such as may suppress or even destroy competition.*"

There are, thus, two complementary categories of antitrust analysis. In the first category are agreements whose nature and necessary effect are so plainly anticompetitive that no elaborate study of the industry is needed to establish their illegality—they are "illegal per se;" in the second category are agreements whose competitive effect can only be evaluated by analysis of the facts peculiar to the business, the history of the restraint, and the reasons why it was imposed. In either event, *the purpose of the analysis is to form a judgment about the competitive significance of the restraint; it is not to decide whether a policy favoring competition is in the public interest, or in the interest of the members of an industry.* Subject to exceptions defined by statute, that policy decision has been made by Congress. At p. 684.

Hence, we must consider whether the restraint promotes

competition or creates anti-competitive effects.

As we indicated above, there are several different anti-competitive effects of this exclusive contract between the hospital and the anesthesiological group. These effects create an unreasonable restraint on competition for anesthesiological services. The anti-competitive affects are:

1. There will be no competition in any form in the provision of anesthesiology services at the hospital;

2. The contract discourages new anesthesiologists from entering the market, tending to create a monopoly;

3. The contract restricts the growth of existing anesthesia groups, thereby suppressing intragroup competition;

4. Neither the surgeon nor the patient have a freedom of choice as to the anesthesiologist to assist during the surgery;

5. An artificial price is paid by both third-party insurers and, in some cases, consumers for the services of an anesthesiologist when in many cases the large majority of work is performed by a nurse anesthetist; and

6. The quality of the care being administered to patients is significantly reduced.

In no fashion can the restraining contract be viewed as promoting competition. The inescapable conclusion is that the combination by contract of East Jefferson Hospital and Roux & Associates is an unreasonable restraint of the trade of anesthesiologists.

CONCLUSION

The exclusive contract between the public hospital and the independent professional corporation of anesthesiologists which establishes a closed shop as to independent anesthesiologists and which compels users of the hospital's surgical facilities to retain the anesthesia services of the corporation, creates a tying arrangement that is illegal per se under the Sherman Act. Furthermore, this arrangement is an unreasonable restraint of trade under the rule of reason.

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2 AND EAST JEFFERSON HOSPITAL BOARD,
Petitioners,

v.

EDWIN G. HYDE,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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BRIEF FOR THE NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS AS AMICUS CURIAE

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INTEREST OF AMICUS CURIAE

Amicus curiae, the National Association of Private Psychiatric Hospitals ("NAPPH"), is the nation's largest organization of hospitals devoted primarily to psychiatric treatment. Founded in 1933, NAPPH currently has 201 member-hospitals located in forty states. Membership in the Association is limited to facilities that have been accredited as psychiatric hospitals by the Joint

Commission on the Accreditation of Hospitals. Approximately one-third of NAPPH's members are hospitals organized as non-profit corporations. The rest are for-profit hospitals, including both independent, "proprietary" facilities and those that are members of multi-hospital organizations owned by publicly-traded corporations.

NAPPH and its member-hospitals are keenly interested in the issues presented in this case. The decision of the Fifth Circuit, while specifically addressing anesthesiology services, has created substantial uncertainty concerning the lawfulness of all "closed" hospital staffs—*i.e.*, staffing arrangements requiring the patient to be treated by a physician provided by the hospital. NAPPH estimates that at least one-third of its members have closed psychiatric staffs. This arrangement greatly facilitates those kinds of intensive psychiatric treatments that require comprehensive staff involvement with patients, typically over long periods of time. These full-time staff become part of the overall therapeutic milieu, thereby establishing continuity and security for very sick and withdrawn patients.

Other NAPPH member-hospitals, which generally offer acute care psychiatric treatment that can be administered in shorter time periods, allow a patient to select his own psychiatrist from among those who have admitting privileges. This arrangement effectively permits the psychiatrist and patient to maintain continuity of care between the hospital and outpatient settings. Collectively, these different approaches enable psychiatric hospitals to provide a wide spectrum of treatment modalities, which is necessary to meet the varying needs of different patients. If closed staff hospitals were to be found unlawful, an important part of this spectrum would be eliminated.

The parties have consented to the filing of this brief. Their letters of consent have been filed with the Clerk.

STATEMENT

Petitioner, East Jefferson General Hospital, is a large public hospital located in the New Orleans metropolitan area in East Jefferson Parish. From 1971 on, all anesthesiology services at the hospital were provided by Roux & Associates, a professional medical corporation of anesthesiologists. These services were provided pursuant to an "exclusive" agreement: the doctors of the Roux group promised to devote all their services to the hospital, and the hospital, in turn, agreed not to engage the services of other anesthesiologists. (Pet. App. 20a-23a).

Petitioner's decision to contract with Roux was based on the hospital's judgment that its anesthesiology department could be run more efficiently through the full-time services of a small group of anesthesiologists than through the part-time services of a large and indeterminate number of anesthesiologists in an "open" department. (Pet. App. 22a, 32a). Under the contracts, Roux undertook responsibility for the administration of the anesthesiology department, the scheduling of all anesthesiology procedures and the supervision of a staff of registered nurse anesthetists employed by the hospital to perform many routine anesthesia procedures.

The financial terms of the contracts allocated to the Roux group a predetermined percentage of all billings of the hospital anesthesiology department. Roux initially received 48 percent of department revenues; its share was reduced to 46 percent in 1976. (Pet. App. 23a-24a, JA 20, 27). Although Roux was permitted to make recommendations to the hospital concerning the fees to be charged to patients for anesthesiology services, the ultimate responsibility for setting fees remained with the hospital.[1]

[1] The Court of Appeals appeared to believe that the fees were set by the Roux group. 686 F.2d at 287. However, the contracts themselves make clear that final authority for the setting of fees was vested in the hospital. See JA pp. 19, 26.

In 1977, respondent, a board certified anesthesiologist, applied for a position on the hospital's medical staff. Based on a review of his credentials, the medical staff recommended that the application be granted. However, the hospital's board of directors rejected that recommendation on the basis of the exclusive contractual arrangement with Roux. (Pet. App. 25a). Respondent then filed this lawsuit, claiming that the Roux contract constituted an unlawful "tie-in" under the Sherman Act, and seeking injunctive relief that would allow him to practice at East Jefferson Hospital.

Decisions Below

The district court rejected respondent's antitrust claim. Although it assumed that the hospital's agreement with Roux tied anesthesiology services to use of the hospital's operating rooms, it concluded that the arrangement produced substantial economic benefits and no discernible anticompetitive effects. In weighing the benefits fostered by the "closed system" anesthesiology department, the district court made the following findings of fact (Pet. App. 32a-33a):

> [The contractual arrangement with the Roux goup] ensures twenty-four hour anesthesiology coverage, aids in the control and standardization of procedures and the efficient and less costly operation of the department; it lends flexibility to the scheduling of operations because it is not necessary to accommodate physicians with outside commitments; it permits the physicians, nurses, and other technicians in the department to develop a work routine and a proficiency with the equipment they use in patient treatment; and it increases the Board's ability to monitor the medical standards exercised because there are fewer individuals involved, maintenance of equipment is simplified, and equipment breakdowns are minimized by limiting use to one group of physicians.

Regarding the competitive consequences of the Roux contract, the district court concluded that East Jefferson

Hospital was without "economic power in the market in which it competes . . ." and was therefore in no position "to charge patients higher prices or to impose burdensome terms which could not be exacted in a completely competitive market." (Pet. App. 34a). Noting that 70 percent of the patients in East Jefferson Parish use hospitals in other parts of the New Orleans area, the court held that, at a minimum, the relevant geographic market included at least twenty hospitals in addition to petitioner. (Pet. App. 38a; 686 F.2d at 290.)

The Court of Appeals reversed, holding that the hospital's closed system anesthesiology department constituted a tie-in that was illegal *per se* under the Sherman Act. The Court began by asserting that the arrangement between the hospital and Roux involved two economically discrete "products" for purposes of tie-in analysis—the hospital operating rooms (the tying product) and anesthesiology services (the tied product). Observing that "users of the hospital's operating rooms . . . are also compelled to purchase the hospital's chosen anesthesia service," the Court asserted that "[i]t is . . . clear that we are dealing with two distinct services which a buyer should be able to obtain separately." 686 F.2d at 289.

Having begun with the proposition that the Roux agreement constituted a tie-in, the Court next determined that East Jefferson Hospital possessed market power in the relevant market for the use of hospital operating rooms. The Fifth Circuit did not suggest that the hospital had been able to elevate prices above competitive levels; on the contrary, the Court expressly found that "the tying of anesthesia services to operating rooms . . . did not lead to a higher charge for anesthesia services." 686 F.2d at 291. Nonetheless, the Court determined that the relevant geographic market was far smaller than the district court had supposed. Finding that East Jefferson Hospital did not face competition from any of the other hospitals in the New Orleans metropolitan area, the Court

concluded, in effect, that petitioner constituted a relevant market unto itself.

In reaching its decision, the Fifth Circuit did not reject any of the district court's factual findings as clearly erroneous. Rather, the Court focused on generic factors that it characterized as "market imperfections in the health care industry." *Ibid.* The Court pointed to the widespread use of third-party insurance, which insulates patients from concern over the costs of health care. The Court also noted the lack of complete information among patients regarding the cost and quality of the health services that they buy. In addition, the Court asserted that "patients tend to choose hospitals by location rather than price or quality." *Ibid.*

Turning to the economic consequences of the closed department system, the Court first observed that the challenged arrangement restricted patients' freedom to choose an anesthesiologist. However, the court identified the reduction in the hospital's costs as the major anticompetitive effect of the Roux contract. By holding down the costs of anesthesiology services, the efficiencies created by the closed department system resulted in increased profits to the hospital—an economic harm, in the Court's view. 686 F.2d at 291-92. The Court, applying a *per se* standard, also gave short shrift to the various justifications that had been advanced for the hospital's arrangement with Roux, concluding that there existed "less restrictive" ways to achieve each of the asserted economic benefits. 686 F.2d at 292.

INTRODUCTION AND SUMMARY OF ARGUMENT

At issue in this case is the lawfulness under the antitrust laws of the common hospital practice of "closing" specialized medical departments in order to achieve efficiencies in the delivery of certain health services. Such closed department arrangements are typically maintained in one of two ways. First, the hospital may enter into a

contractual agreement with a group of medical specialists, designating that group as the exclusive provider of a particular medical service. Second, the hospital may decide to integrate a particular department or service into its own operations by hiring a staff of doctors and related professionals to furnish all medical services of a particular type.

Until now all antitrust challenges to closed department arrangements have been turned aside by the federal courts. See *Smith v. Northern Michigan Hospitals, Inc.*, Nos. 81-1513 (6th Cir. March 25, 1983); *Dos Santos v. Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346 (7th Cir. 1982); *Capili v. Shott*, 620 F.2d 438 (4th Cir. 1980); *Harron v. United Medical Center Inc.*, 522 F.2d 1133 (4th Cir. 1975), *cert. denied*, 424 U.S. 916 (1976); *Robinson v. Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981), *aff'd mem.*, 688 F.2d 824 (3d Cir.), *cert. denied*, No. 82-415 (Nov. 1, 1982). Recognizing that such arrangements may actually facilitate competition rather than harm it, these courts have properly declined to invoke a rule of *per se* illegality.

Amicus submits that the decision below cannot be sustained. We first show that the Fifth Circuit's decision amounts to nothing less than wholesale condemnation under a tie-in theory of the fundamental principle of economically integrated production. Seen in this light, the Court's decision represents a radical and wholly unjustified extension of the rule of *per se* illegality in antitrust cases.

Having demonstrated that the Court of Appeals used the wrong standard of analysis, we next show that the Court erred in holding that petitioner's combined sale of operating room time (the alleged tying product) and anesthesiology services (the alleged tied product) constitute a tie-in. Amicus contends that the separability of the components of such a transaction should not cause it

to be condemned without a full consideration of its competitive consequences. Viewed in those terms, a closed staff arrangement plainly has many procompetitive effects and causes little, if any, restraint on competition.

Finally, we show that the Fifth Circuit used an incorrect analysis in holding that East Jefferson Hospital possesses economic power in the market for the alleged tying product. There is simply no merit to the suggestion that petitioner constitutes a relevant geographic market unto itself.

ARGUMENT

I. The Court of Appeals' Decision Represents a Radical and Wholly Unsupported Application of the Per Se Doctrine in Antitrust Analysis

The Court of Appeals' decision turns the antitrust laws on their head by condemning as *per se* illegal an economic arrangement whose obvious purpose—and demonstrated effect—is to enhance efficiencies in the delivery of a particular health service to consumers. The Fifth Circuit's decision thus represents a radical, and wholly unwarranted, extension of the Sherman Act's rule of *per se* illegality.

The classification of petitioner's contract with the Roux group as an unlawful tie-in rests on two key propositions. The first is that the "packaged" sale of a combination of medical services constitutes a tying arrangement whenever the components of the package are theoretically separable. Thus, anesthesiology services are tied to the use of hospital operating rooms, in the Court's view, because a patient undergoing surgery *could* engage the services of an anesthesiologist who is not part of the Roux group.[2]

[2] It should be noted that this analysis attaches no relevance to the existence of a contract between Roux and the hospital; the same tie-in classification would apply to any hospital-based good or service, whether furnished by independent contractors or full- or part-time employees.

The second proposition is that every hospital is a monopolist, or at least has sufficient market power to trigger *per se* analysis under the Sherman Act. This follows from the Court's definition of the relevant market on the basis of generic factors applicable throughout the health industry.

If this analysis is correct, it follows that every hospital in the country is a labyrinth of antitrust violations. At a minimum, of course, the Court's decision extends to all hospitals employing closed staff arrangements for various medical specialties. Such arrangements are, as the district court found, "common practice in the health care industry." (Pet. App. 32a). *See Dos Santos v. Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346, 1351 (7th Cir. 1982). *See generally* D. Horan & N. Nord, *Application of Antitrust Law to the Health Care Delivery System*, 9 Cumberland L. Rev. 685 (1979). The Court's decision does not stop here, however. Equally suspect under the Fifth Circuit's analysis is the routine provision by hospitals of meals, linen service, nursing care, blood, pharmaceuticals, and myriad other goods and services furnished either by hospital employees or independent suppliers under contract with the hospital. Such economic "inputs" are provided to patients as part of a package of hospital-based health care services. If the Court below is correct, the failure to make available each of these goods or services on an *a la carte* basis constitutes a tie-in, unlawful *per se* on the basis of the hospital's presumed market domination.

Nor can the Court of Appeals' reasoning be meaningfully confined to the health care industry. There is no end to the list of theoretically separable products that are sold in combination as a single "good." Shirts with buttons, automobiles with tires, flashlights with bulbs, a hamburger with a bun, and right shoes sold together with left shoes are all examples of tying arrangements under the Fifth Circuit's reasoning, and all must be invalidated un-

der the Sherman Act, provided the requisite market power can be shown. Little familiarity with economic theory is necessary to see that these products are not usually sold together for the purpose of extending economic power from one product market to another—the principle economic harm to which the tie-in doctrine is addressed. See *United States Steel Corp. v. Fortner Enterprises, Inc.*, 429 U.S. 610, 617 (1977) ("Fortner II"). On the contrary, they are sold together in most, if not all, instances for the purpose of realizing efficiencies available through economically integrated production.

If nothing else, the implications of the Court of Appeals' reasoning establish that the contractual arrangement between petitioner and the Roux group should not be analyzed under a rule of *per se* illegality. Such rules "are appropriate only when they relate to conduct that is manifestly anticompetitive." *Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 49 (1977). They are to be narrowly confined to "naked restraints of trade [having] no purpose except stifling of competition," *White Motor Co. v. United States*, 372 U.S. 253, 263 (1953), and whose "nature and necessary effect are so plainly anticompetitive that no elaborate study of the industry is needed to establish their illegality . . ." *National Society of Professional Engineers v. United States*, 435 U.S. 679, 692 (1978). As this Court recently stated, the inquiry must be whether the challenged practice "facially appears to be one that would always or almost always tend to restrict competition . . ." *Broadcast Music, Inc. v. Columbia Broadcasting System*, 441 U.S. 1, 19-20 (1979).

Judged against these standards, the Court of Appeals' decision must be set aside. At a minimum, the hospital practice at issue warrants more careful analysis than the *per se* rule permits. While it would thus be appropriate to remand this case for further consideration under a proper legal standard, we thing the record already demonstrates that East Jefferson Hospital's arrangement with

Roux should be encouraged under the antitrust laws, not condemned by them. Far from restraining competition in the provision of anesthesiology services, the arrangement, as we will now show, operates to "increase economic efficiency," thereby rendering the "market more rather than less" competitive. *United States v. United States Gypsum Co.*, 438 U.S. 422, 441 n.16 (1978).

II. Petitioner's Contractual Arrangement With the Roux Group Either Should Not Be Classified as a Tie-in or, If So Classified, Should be Upheld Because of its Manifestly Procompetitive Effects

In striking down the closed staff arrangement, the Court of Appeals reasoned that petitioner's contract with the Roux group constituted an unlawful tie-in because of the theoretical separability of the tying product (emergency room time) and the tied product (anesthesiology services). Observing that patients undergoing surgery are "compelled to purchase the hospital's chosen anesthesia service," the Court concluded that "we are dealing with two distinct services which a buyer should be able to obtain separately." 686 F.2d at 289. This analysis reflects a fundamental misunderstanding of the economic realities that support exclusive contracts or other closed staff arrangements in a hospital setting.

Believing that its inquiry was restricted by the *per se* standard, the Court of Appeals ignored the procompetitive effects of petitioner's exclusive contract with Roux & Associates. The Court was thus able to find a tie-in by concluding that the practice involved two discrete products rather than the single product of hospital-based medical services.[3] In our view, this approach is fundamentally

[3] The Court also found that the arrangement had an anticompetitive effect since it restricted competition in the market for anesthesiology services. See 686 F.2d at 292. While we think that this analysis was essentially misguided, see p. 17 *infra*, the basic fact is, of course, that any form of vertical integration necessarily causes some degree of market foreclosure.

flawed. While it is true that "the traditionally stringent *per se* rule of liability [has been] applied in [tie-in] cases[,]" 686 F.2d at 292-93, many courts have nevertheless scrutinized the full range of competitive effects caused by the challenged practice. Such an approach, even if it employs the *per se* rubric, is functionally equivalent to the application of a "Rule of Reason" standard.

A meaningful antitrust analysis of closed system medical departments or other complicated economic arrangements obviously requires more than a hollow counting of products. In the area of alleged tie-ins, as elsewhere in antitrust litigation, "easy labels do not always supply ready answers." *Broadcast Music, Inc.* v. *Columbia Broadcasting Co., supra*, 441 U.S. at 7. To the contrary, this Court's cases make clear that the mere separability of two products or services is not sufficient to classify their combined sale as a tie-in. Careful consideration of the economic consequences of the challenged practice is also required.

In *Times-Picayune Publishing Co. v. United States*, 345 U.S. 594 (1953), for example, the Court determined that the sale of classified advertising in two separate newspapers constituted only a single product for antitrust purposes. Looking beyond mere separability, the *Times-Picayune* decision examined the nature and function of the allegedly tied products and the economic consequences of the challenged arrangement. 345 U.S. at 613. Although the two products were distinct in a purely formal sense, the Court concluded that their joint sale did not implicate the core concerns of the tie-in doctrine—"the forced purchase of a second distinct commodity . . . resulting in economic harm to competition in the 'tied' market." *Id.* at 614.

In *Automatic Radio Manufacturing Co. v. Hazeltine Research Inc.*, 339 U.S. 827 (1950), a case involving a claim of alleged patent misuse, the Court again declined to characterize as a tie-in an arrangement in which the-

oretically separable goods were sold as a single package. The plaintiff in *Automatic Radio Manufacturing* challenged a patent licensing agreement under which it was required to pay royalties for the use of all of defendants' patents, irrespective of the number of patents actually used. There, as here, there was little doubt that the patent owner *could* have licensed each of its patents separately. However, the Court found that the arrangement "create[d] no restraint of competition beyond the legitimate grant of the patent," 339 U.S. at 833, and promoted efficiency by providing "a convenient mode of operation designed . . . to avoid the necessity of determining whether each . . . product embodies any of the numerous Hazeltine patents." *Ibid.*

More recently in *Fortner II*, *supra*, the Court rejected the claim that United States Steel had unlawfully tied the sale of prefabricated housing (the tied product) to the provision of real estate financing (the tying product). Although bound by its earlier characterization of this arrangement as a tie-in in *United States Steel Corp. v. Fortner Enterprises, Inc.*, 394 U.S. 495 (1969) ("Fortner I"), the Court nevertheless ruled that such an aggregation of products could not be regarded as illegal if the arrangement is supported by legitimate economic considerations and the "package price," if not the price of each item separately, is competitive.[4]

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[4] In sharp contrast to the rigid approach of the Fifth Circuit, other Courts of Appeals have looked to the economic substance of an arrangement to determine whether it amounts to an unlawful tie-in. *See, e.g., Principe v. McDonald's Corp.*, 631 F.2d 303 (4th Cir. 1980), *cert. denied*, 451 U.S. 970 (1981); *Krehl v. Baskin-Robbins Ice Cream Co.*, 664 F.2d 1348 (9th Cir. 1982); *Hirsh v. Martindale-Hubbell Inc.*, 674 F.2d 1343 (9th Cir.), *cert. denied*, No. 82-570 (Nov. 1, 1982). Rather than focusing on the separability of the aggregated items, these courts have stressed the "function of the aggregation" itself, *Principe v. McDonald's Corp.*, *supra*, 631 F.2d at 308, and the "relationship" between the alleged tying product and the alleged tied product, *Krehl v. Baskin-Robbins Ice Cream Co.*, *supra*, 664 F.2d at 1353. As stated by the Ninth Circuit in

As these cases demonstrate, whether an economic arrangement may be condemned as an unlawful tie-in is a matter of economics, not semantics. Thus, rather than devote our efforts to a hair-splitting inquiry into the number of products involved in a closed staff arrangement, we will focus instead on the economic substance of that practice. Viewed in those terms, a closed staff arrangement should clearly survive antitrust scrutiny.

To begin with, petitioner's contractual arrangement should not be regarded as unlawful because its purpose and effect is to achieve efficiencies in the delivery of health care to "consumers"--the patients of the East Jefferson Hospital. Both the district court and the Court of Appeals found that petitioner's closed department system had *reduced*—not increased—the costs of providing anesthesiology services. (Pet. App. 32a; 686 F.2d 291). Contrary to the Fifth Circuit's view, the fact that these cost savings also resulted in higher profits for the hospital is of no relevance to the legality of the arrangement.[5] It is the potential for increased profits, of course, that motivates all firms, including hospitals, to introduce innovations that either reduce cost or enhance quality.

Hirsh v. Martindale-Hubbell, Inc., supra, the test is "whether the aggregation serves to facilitate competition by promoting product quality or whether it, in fact, amounts to no more than a naked effort to impede competition on the merits." 674 F.2d at 1347.

[5] Similarly, petitioner's higher profits from the anesthesiology department do not necessarily suggest that East Jefferson Hospital possessed market power. See pp. 18-22, *infra*. Although in a perfectly competitive market cost-savings generated through efficiencies in production are ordinarily passed on to consumers, the efficiencies in petitioner's anesthesiology department may have been—and, in all likelihood, were—offset by inefficiencies (and lower profits) in other departments. Since the relevant product here is hospital-based medical services in the aggregate, an inference of market power would only be reasonable if petitioner's overall profits—for all departments and services—were at supracompetitive levels for an extended period of time. The record in the case does not support such a finding.

In assessing the economic substance of the challenged arrangement, one must begin by asking *why* petitioner would want to enter into an exclusive contract for the provision of anesthesiology services. As a general hospital providing surgical facilities and services, petitioner had to assure the availability of anesthesiology services, and could have done so in several ways. East Jefferson Hospital could simply have "opened" its staff to all competent anesthesiologists desiring to practice at the hospital. Alternatively, it could have hired a full-time staff of anesthesiologists who would work directly for the hospital as employees. And finally, it could enter into an exclusive contract with an outside group of anesthesiologists, such as Roux & Associates. Amicus submits that petitioner's choice of the last option can only be explained on the basis that it believed a closed system anesthesiology department would produce the optimal combination of quality and cost. Absent extraordinary circumstances clearly not present here,[6] there simply can be no other answer.

The efficiencies made possible by petitioner's contractual arrangement with Roux relate essentially to the ration-

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[6] One can imagine a situation in which a hospital's management is dominated or controlled by the medical specialists whose closed department is subject to challenge. In such circumstances it is possible that an exclusive contract or other closed system arrangement could be used to facilitate horizontal collusion among the specialists in control, at the expense of the hospital's separate interest in minimizing costs or enhancing quality. In view of the historical role played by medical staffs in protecting quality care, we believe that such collusion may never be presumed merely on the basis of the identity of the hospital's managers and owners, or other aspects of the hospital's organization. To be given any weight, such collusion must be affirmatively proven by direct evidence. In the instant case, of course, the medical staff at East Jefferson Hospital recommended in favor of respondent's admission to the hospital staff. Moreover, there was no evidence that the closed department arrangement resulted in increased prices for anesthesiology services—the inevitable consequence of collusion among medical specialists.

alized use of the hospital's limited resources. As found by the district court, petitioner's contract with the Roux group (1) ensures anesthesiology coverage on a twenty-four hour basis; (2) facilitates the standardization of anesthesiology procedures and services; (3) permits greater flexibility in the scheduling of operations by eliminating the need to accommodate physicians' outside commitments; (4) enables the medical team of physicians and skilled nurse anesthetists to develop a work routine and to maximize proficiency; (5) reduces the cost of equipment maintenance by limiting access to a small group of doctors; and (6) enhances the hospital's ability to monitor the quality of patient care. (Pet. App. 32a-33a.)

These are not merely hypothetical or speculative benefits, but real and substantial efficiencies that are likely to obtain in *any* closed department system for the delivery of medical services. *See* D. Horan & R. Nord, *Application of Antitrust Law to the Health Care Delivery System*, *supra*, at 702. Indeed, a closed staff may be virtually essential for certain kinds of patients. In the mental health area, for example, some patients need long-term and intensive treatment that often requires that the psychiatrist be available to plan and monitor the full range of the patient's daily activities. A relatively small, stable medical staff, moreover, enhances the sense of community and security that is important to patients—particularly children and adolescents—who require long-term psychiatric treatment. In addition, the use of a closed staff allows physicians to become familiar with the psychiatric problems of many patients, thereby facilitating collaborative efforts in making difficult treatment decisions. In view of these considerations, an antitrust prohibition against closed staffs could effectively deny certain patients an important type of treatment altogether.

Even if it could be suggested that some of these benefits might be achieved in other "less restrictive" ways, 680

F.2d at 292, the suggestion is immaterial for antitrust purposes. One can always imagine some theoretically less restrictive arrangement that, in a purely hypothetical world, would yield comparable benefits. *Cf. Illinois Election Board v. Socialist Workers Party*, 440 U.S. 173, 188 (1979) (Blackmun, J., concurring) ("A judge would be unimaginative indeed if he could not come up with something a little less 'drastic' or a little less 'restrictive' in almost any situation"). In the real world, of course, it is likely that the imagined alternative would either exact a higher cost, yield fewer benefits, or both.[7]

The use of a closed staff arrangement in a hospital setting thus makes possible important efficiencies that should not be disregarded in an antitrust analysis. On the other hand, it is difficult to see what anticompetitive effects are likely to result from such an arrangement. To be sure, it might be argued that a closed staff limits competition among physicians for patients—a proposition advanced by the Fifth Circuit in this case. 686 F.2d at 292. While this is doubtless a form of economic "restraint," its anticompetitive impact is at most very limited, and more likely nonexistent. The fact is that in many cases patients do not "choose" a physician in the same sense that a consumer traditionally makes purchasing choices. Instead, they are generally referred by other doctors or rely on the hospitals to provide a competent staff. In these circumstances, a hospital, by effectively acting as a joint purchasing agent for its patients, can stimulate competition among physicians through the use of a closed staff or an exclusive contract. To participate in such a program, of course, physicians must compete on the basis of price or quality—competition that ultimately inures to the benefit of patients.

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[7] The problem is that this proposition can never be conclusively established in a judicial setting. The result is that application of the "least restrictive alternative" test in antitrust cases leads ineluctably to invalidation of the challenged arrangement.

In addition, if a patient does in fact want to select his own physician who is not a member of the closed staff, he is always free to go to another hospital where that physician has privileges. See pp. 20-21, *infra*. Obviously, a hospital that employs a closed staff takes that competitive risk in return for the benefits it secures. The net effect is to encourage competition since the consumer is given a choice between the efficiencies of a closed staff hospital and the opportunity to select his own physician at an open staff hospital.

For these reasons, we believe that it would disserve the purposes of the antitrust laws to treat closed staffs or exclusive contracts for physician services as unlawful restraints of trade. In common sense terms, a hospital is much more than a hotel. A patient obviously purchases a package of medical services which, depending on the nature of the patient's illness, may include both surgery and anesthesiology services. Although there may be valid reasons for unbundling this package in certain circumstances—by allowing a patient to select his own physician, for example—there are equally good reasons for keeping the package intact. As long as a hospital makes an independent business judgment to use a closed staff, there is no reason to suspect that the effects of such a decision will be anticompetitive.

III. The Court of Appeals Erred in Determining that East Jefferson Hospital Possessed Market Power

Even assuming that the exclusive contract with Roux Associates may be labelled a tie-in, it may not be invalidated unless it can also be shown that East Jefferson Hospital possessed sufficient market power in the tying product—here, hospital beds. See, *e.g.*, *International Salt Co. v. United States*, 332 U.S. 392 (1947); *Northern Pacific Railway v. United States*, 356 U.S. 1 (1958). On this ground alone, the decision below should be reversed. By finding East Jefferson to be a virtual monopolist for the provision of hospital services, the Court of Appeals

took an artificially cramped view of competition among health care providers.

As discussed earlier, the Fifth Circuit rejected the district court's finding that East Jefferson Hospital competed with other hospitals in the New Orleans metropolitan area. Although the Court of Appeals did not set aside the district court's findings, it nonetheless held that traditional principles of market definition do not apply to the health care industry. Relying on generic factors that it labelled as "market imperfections," the Court concluded that the relevant geographic market consisted only of the East Bank of Jefferson Parish. 686 F.2d at 291. In effect, the Court below held that petitioner constituted a relevant market unto itself.

The Court of Appeals' analysis is misconceived for at least two reasons. First, the Court failed to apply the functional market analysis required by this Court's tie-in cases. The seller of allegedly tied products may not be subject to a rule of *per se* illegality unless the "tying" product is determined to be so unique or distinctive as to confer on the seller a substantial advantage not shared by his competitors. See e.g., *International Salt Co. v. United States, supra; United States v. Paramount Pictures, Inc.*, 334 U.S. 131 (1948); *United States v. Loew's, Inc.*, 371 U.S. 38 (1962); *Northern Pacific Railway Co. v. United States, supra.* As the Court stated in *Fortner II, supra*, 429 U.S. at 620, the question is "whether the seller has the power, within the market for the tying product, to raise prices or to require purchasers to accept burdensome terms that could not be exacted in a completely competitive market."

These indicia of market power are wholly lacking in this case. There was no suggestion that petitioner's operating rooms were in any sense distinctive, much less "unique" enough in terms of quality and price to impart to petitioner a major competitive advantage. Nor was

there any evidence, direct or indirect, that East Jefferson Hospital was able to influence the price of operating room time or to impose "burdensome" conditions on patients or doctors with respect to the sale of that time. On the contrary, the district court expressly found that East Jefferson Hospital, as one of 20 hospitals in a nearby portion of the New Orleans area, was without the power to engage in anticompetitive practices of this type. (Pet. App. 34a).

Second, and more important, the Court of Appeals' rigidly narrow market definition—effectively excluding from the relevant market all hospitals other than petitioner—cannot be sustained. The various factors on which the Court relied, while not irrelevant to an assessment of the functioning of the market for hospital-based services, do not justify the extraordinary conclusion that the economically relevant market in this case embraced only East Jefferson Hospital. As discussed earlier, it follows inescapably from that conclusion that every hospital in the country is a monopolist, or at least enjoys sufficient market power to trigger *per se* analysis under the tie-in doctrine.

The Court relied heavily on a perceived consumer preference for neighborhood hospitals. Pointing out that most of petitioner's patients reside in East Jefferson Parish, the Court found that "patients tend to choose hospitals by location rather than price or quality." 686 F.2d at 290. Although some consumers may favor hospitals located close to home, that mild preference hardly translates into market power. By that logic every regional brand of beer is a monopolist, notwithstanding intense competition from national brands; and every neighborhood grocery is a monopolist, even though it may be located a block away from a major supermarket. Obviously, the relevant question is not whether most of East Jefferson Hospital's patients are drawn from the local community, but whether most of the patients in the local

community use East Jefferson Hospital. On this point the record is unambiguous: the district court found as fact that more than 70 percent of all East Jefferson Parish residents use hospitals *other than petitioner*. (Pet. App. 33a). There can be no question but that petitioner competes with these other hospitals.

The Court of Appeals also relied on the judicially noticed "facts" that consumers are indifferent to the costs of medical care because of the pervasiveness of third-party insurance and a lack of information concerning the quality of medical services. Whatever the merit of these asserted "market imperfections," it is clear that they too are insufficient to support the conclusion that petitioner, by itself, constitutes a relevant geographic market. Other courts presented with similar arguments have declined to slice the market so small. See e.g., *Dos Santos v. Columbus Medical Center*, *supra*, 684 F.2d at 1353; *Robinson v. Magovern*, 521 F. Supp. 842, 878, *aff'd mem.*, 688 F.2d 824 (3d Cir.), *cert. denied*, No. 82-415 (Nov. 1, 1982). Although competition plays a different and more complicated role here than in other industries, it is simply not the case that hospitals and other providers of medical services can raise prices and reduce quality with impunity, free from fear that such actions will result in a loss of market share. On the contrary, hospitals compete intensively on the basis of the quality of medical care. See C. Havighurst, *Regulation of Health Facilities and Services by 'Certificate of Need,'* 59 Va. L. Rev. 1143, 1162-63 (1973). And in certain areas of the industry—for example, competition between health maintenance organizations and more traditional providers—competition on the basis of price is highly significant. See Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 Harv. L. Rev. 887 (1971).

In sum, there is no basis for the Fifth Circuit's conclusion that petitioner possesses market power. In the absence of evidence that East Jefferson Hospital has been

able to influence prices or take other anticompetitive action, economic power simply cannot be presumed on the basis of theoretical "market imperfections" or other generic factors. On its face, the Court's finding that petitioner was immune from competitive pressures makes no sense. The more reasonable conclusion, we submit, is that petitioner entered into the challenged arrangement not because of indifference to competitive pressures, but precisely to *respond* to competitive pressures to hold down the costs, and to enhance the quality, of medical services.

CONCLUSION

For the foregoing reasons, amicus submits that the decision of the Court of Appeals for the Fifth Circuit should be reversed.

Respectfully submitted,

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No. 82-1031

In the Supreme Court of the United States

OCTOBER TERM, 1982

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2, ET AL.,
PETITIONERS

v.

EDWIN G. HYDE

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE IN SUPPORT OF REVERSAL

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QUESTION PRESENTED

Whether a hospital that combines the sale of anesthesiology services with the sale of operating room facilities, as a result of an exclusive dealing contract between itself and a single group of anesthesiologists, may be held to have engaged in a "tie-in" that is per se unlawful under the Sherman Act.

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In the Supreme Court of the United States

OCTOBER TERM, 1982

No. 82-1031

JEFFERSON PARISH HOSPITAL DISTRICT NO. 2, ET AL., PETITIONERS,

v.

EDWIN G. HYDE

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE IN SUPPORT OF REVERSAL

INTEREST OF THE UNITED STATES AND THE FEDERAL TRADE COMMISSION

The United States and the Federal Trade Commission, which have primary responsibility for enforcement of the federal antitrust laws, have a substantial interest in assuring that the Sherman Act is construed in a manner that advances, rather than impedes, the Act's objectives.

STATEMENT

1. This case involves a common practice in the health care industry—an arrangement in which a hospital contracts with a group to be the exclusive provider of a particular service to the hospital and its patients. In considering the legal issues presented it will be helpful to recognize the factual landscape in which they are set. For a hospital to compete effectively in the market for surgical procedures, or indeed for any medical treatment, it must provide the full panoply of associated goods and services: operating, recovery and patient rooms; surgeons, anesthesiologists, nurses, and attending staff; and equipment, medicines,

bandages, beds, etc. The failure to offer any of these essential components of surgery would undermine the hospital's competitive posture in relation to other facilities.

The hospital will ordinarily have several options in deciding how to procure and provide these services. It may (1) hire professionals to fill an allotted number of staff positions; (2) contract with a group of professionals for it to be the exclusive provider of such services; or (3) establish an open staff system that allows any qualified practitioner to obtain staff privileges.

The hospital involved in this case chose to have an exclusive dealing arrangement with a group of anesthesiologists. Thus, the services of that group were among the items provided to surgical patients when they selected the hospital for their medical care.

2. Petitioner Jefferson Parish Hospital District No. 2 owns East Jefferson District Hospital ("East Jefferson" or "Hospital"). Pet. App. 20a. The Hospital is located in Metairie, Louisiana, a suburb of New Orleans. Prior to its opening in 1971, the Hospital entered into a contract with Roux & Associates ("Roux"), a professional medical corporation, for Roux to be the exclusive provider of anesthesia services for the Hospital. *Id.* at 22a. In 1976, the contract was renewed, and Roux continues to provide all anesthesia services at the Hospital. *Id.* at 23a.[1] As a result of this contract, patients who are operated on at the Hospital must use the anesthesiology services of the Roux group.[2]

Respondent, Dr. Edwin Hyde, is a licensed and board certified anesthesiologist who chairs the anesthesiology department at Lakeside Hospital in New Orleans. Pet. App. 2a, 30a. When he applied for staff privileges at East Jefferson, the Hospital's Credentials Committee recommended that Hyde be appointed to the staff, but the Board

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[1] At Roux's request the contract language designating Roux as the exclusive provider of anesthesia services was deleted in 1976; the Hospital, however, has maintained its practice of relying exclusively on Roux for these services. Pet. App. 23a.

[2] There was testimony at trial that doctors who are not on the Hospital medical staff could apply for temporary privileges on a case by case basis. Pet. App. 23a.

of Directors refused him privileges because of the exclusive contract with Roux. *Id.* at 25a-26a.

Hyde brought this antitrust suit in the United States District Court for the Eastern District of Louisiana, claiming that the Hospital had tied the use of Roux's anesthesia services to purchase of the Hospital's surgical facilities and that this conduct violated Section 1 of the Sherman Act, 15 U.S.C. 1. Pet. App. 36a-37a.[3]

3. The district court dismissed the complaint. Although it assumed there was a "tie" of two separate services,[4] the district court rejected respondent's claim of per se illegality. First, the court held that the professions are not subject to the same per se rules applicable to other businesses. Pet. App. 37a, 39a. It also ruled that the arrangement was not illegal per se since the Hospital did not have dominant power in the market for surgical facilities, the tying product. *Id.* at 38a. This ruling rested on its finding (*id.* at 33a-34a) that the geographic market in which the Hospital competes (the New Orleans metropolitan area) included at least 20 other hospitals that provided the same surgical services. These hospitals serve the large majority of residents who live in the vicinity of East Jefferson Hospital; indeed 70% of patients who live on the East Bank of Jefferson Parish (where the Hospital is located) go to hospitals other than East Jefferson. *Id.* at 33a. The court also found that traditional indicia of market power were lacking: the tying product was not unique and similar packages were available from other local facilities; the Hospital's prices were no higher than its competitors' nor were its terms of supply

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[3] Respondent also alleged violations of the Fourteenth Amendment and of state law. The district court dismissed those claims. Pet. App. 42a-47a. The court of appeals did not reach those issues (*id.* at 5a n.3), and they are not before this Court.

[4] The only finding on this issue was that anesthesia service appears as a separate item on the patient's bill. Pet. App. 33a.

more burdensome; and there was no indication that unwilling patients were coerced to take a product on unsatisfactory terms. *Id.* at 37a-38a.[5]

The district court therefore applied the rule of reason to petitioners' conduct and found it reasonable. It noted significant efficiencies that result from the exclusive contract with Roux: improved round-the-clock coverage, better control and standardization of procedures, and more efficient and less costly operation of the department.[6] And it concluded that, given the relevant market, the benefits of the closed system outweighed any "minimal" foreclosure of Roux's competitors.

4. The court of appeals reversed (Pet. App. 1a-19a), concluding that the Hospital's contract with Roux was illegal per se.[7] *Id.* at 14a-15a. The court stated that there was a "tie" of "two distinct services which a buyer should be able to obtain separately," *i.e.*, surgical services and anesthesia services. *Id.* at 5a, 6a. Next, the court rejected the dis-

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[5] The district court found that most surgeons have privileges at more than one hospital; thus, they can take their patients to another hospital if they prefer a particular anesthesiologist. Pet. App. 34a. Patients have the same choice. *Ibid.*

The court also found that it is common practice in the health care industry for hospitals to enter into exclusive contracts with physicians engaged in certain hospital-based specialties, such as anesthesiology, radiology and pathology, to insure the availability of these services to their patients; and that, generally, a patient does not specifically select a particular specialist to perform these services. Pet. App. 32a. In the court's view, these factors increased the hospital's responsibility to provide quality service. *Ibid.*

[6] The court found that such a system lends flexibility to the scheduling of operations because it is not necessary to accommodate physicians with outside commitments; it permits the doctors, nurses, and technicians in the department to develop a work routine and a proficiency with the equipment; it increases the Hospital's ability to monitor performance because fewer individuals are involved; and maintenance of equipment is simplified and equipment breakdowns reduced as a result of use by fewer doctors. Pet. App. 32a-33a.

[7] The court held that per se rules under the Sherman Act are as applicable to the health care industry as to other industries. Pet. App. 14a-18a. See *Arizona* v. *Maricopa County Medical Society*, 457 U.S. 332 (1982).

trict court's finding that the proper geographic market for the tying product included hospitals in Orleans Parish because, in its view, imperfections in the health market (due to third-party payors, and inability of patients to compare the quality of medical care) deprive consumers of the incentive to shop for quality or lower costs; consumers were therefore deemed likely to select the hospital closest to their homes. *Id.* at 9a. The court thus found the relevant market to be the East Bank of Jefferson Parish, a market "much smaller than the district court found" and one in which the Hospital "ha[s] sufficient market power * * * to coerce purchase of the tied product." *Id.* at 10a. The court's finding of market power was based on the fact that nearly one-third of the patients from the East Bank of Jefferson Parish go to the Hospital. *Ibid.*

Addressing the anticompetitive effects of the challenged practice,[8] the court acknowledged that the "tie-in" did not result in higher charges for anesthesia services. Pet. App. 11a. It found, however, that "it accomplished just as dramatic an effect by increasing the hospital's profit" by enabling the Hospital to "supplement[ ] a small contract group of anesthesiologists with a larger group of lower priced [paraprofessional] anesthetists." *Id.* at 11a-12a. The court found that the contract produces "a number of anticompetitive effects:" it prevents anesthesiologists from entering the portion of the market controlled by the hospital; it indirectly limits the number of anesthesiologists in the area, and reduces the incentive for improving quality; and it limits the surgeon's or patient's choice of anesthesiologist. *Id.* at 12a. In addition, the court rejected the contention that competition still exists at the point where the contract for anesthesiology is awarded by the Hospital, because the Hospital "has not permitted this competition since the original contract was signed over ten years ago." *Id.* at 12a n.9. The court also rejected the "business justifications" for the contract because, in the court's view, the

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[8] It was apparently not disputed that the practice involved a "not insubstantial" volume of interstate commerce, as the district court (Pet. App. 3a) and court of appeals (*id.* at 13a n.10) both found.

same objectives could be achieved through less restrictive alternatives. *Id.* at 14a.

SUMMARY OF ARGUMENT

1. The court of appeals mischaracterized the exclusive dealing arrangement at issue here as a "tie-in" by focusing solely on the combined sale of surgical facilities and anesthesiology services without appreciating that the combined sale resulted automatically from the exclusive dealing arrangement between the Hospital and the Roux group. This mechanical adherence to labels elevated form over substance and led the court to brand the Hospital's conduct as a "tie-in" and, accordingly, to condemn it as illegal per se without fully considering the procompetitive effects the district court had found. Even if the challenged practice is viewed as a "tie-in," the court of appeals' analysis is legally deficient in several respects; first, it erred in concluding that, merely because surgical and anesthetic services *could* be sold separately, they *must* be. Second, it improperly rejected the district court's definition of the relevant geographic market and then, within this smaller market, used inappropriate guidelines for assessing the Hospital's market power.

2. The ease with which the court of appeals could transform an exclusive dealing contract, subject to scrutiny under the rule of reason, into a "tie-in" that is illegal per se, illustrates one of the difficulties inherent in the tying doctrine. Although this Court has, since *Internationl Salt Co.* v. *United States*, 332 U.S. 392 (1947), placed tying arrangements in the category of per se offenses, it has not accepted the simplistic approach employed by the court of appeals. Instead, the tying doctrine has evolved in a manner quite unlike other per se rules. Whereas other per se violations are established without regard to competitive impact, the tie-in rules laid down by this Court explicitly require an inquiry into facts peculiar to the products and markets at issue to determine whether a foreclosure effect exists. Moreover, some of the lower courts, following this Court's lead, have scrutinized whether a practice is justified by business reasons or lack of anticompetitive effect in order to avoid

per se condemnation of "tie-ins" that do not threaten competition. This is of course more consistent with the rule of reason approach applied to conduct that does not invariably have a "pernicious effect on competition" and that may have some "redeeming [competitive] virtue." *Continental T.V., Inc.* v. *GTE Sylvania, Inc.*, 433 U.S. 36, 49-50 (1977). Accordingly, we believe it would now be appropriate for the Court expressly to confirm that alleged tie-ins should be scrutinized to determine whether market conditions are such that anticompetitive effects could be realized and, in those instances, whether sufficient justifications nevertheless exist to permit the challenged practices.

3. The course we suggest is not an abrupt or radical departure from current law. First, the more discerning opinions have already adopted analyses that incorporate traditional competitive impact factors. Second, economists and legal scholars have recognized that the instances in which alleged "tie-ins" in fact produce anticompetitive effects arise only in limited circumstances. These relatively few instances do not justify the proscription of a broad category of conduct that in many cases is procompetitive. Moreover, where anticompetitive effects are shown, and they outweigh economically beneficial effects, antitrust liability will still be imposed—but with the assurance that only demonstrably pernicious conduct will be penalized.

ARGUMENT[9]

I. THE COURT OF APPEALS MISAPPLIED PREVAILING ANTITRUST LAW IN TREATING THE HOSPITAL'S CONTRACT WITH ROUX AS A TIE-IN AND, HENCE, ILLEGAL PER SE

The court of appeals erred in treating the arrangement between the Hospital and Roux as a "tie-in," governed by a per se standard of illegality, rather than as an exclusive dealing contract whose legality is judged by the rule of reason. All other courts of appeals that have addressed the is-

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[9] The Federal Trade Commission joins in Section I of this brief; it also supports the general conclusions of Sections II and III, that the legal treatment of tying arrangements should be clarified to take into account the relevant economic and competitive factors.

sue have treated exclusive arrangements between hospitals and physicians as vertical restrictions subject to the rule of reason.[10] The Fifth Circuit, however, failed to recognize that the combined sale of anesthesiology and surgical services by the Hospital resulted automatically from and, as a practical matter, was required by the arrangement under which Roux provided all of the anesthesiology services in the Hospital. Since the legality of the exclusive dealing contract is judged under the rule of reason, *Tampa Electric Co.* v. *Nashville Coal Co.*, 365 U.S. 320, 333-335 (1961), neither logic nor antitrust policy is served by judging the resultant and ancillary combined sale by a per se standard.

In addition to its error in condemning the Hospital's practice as per se unlawful, the court's analytical path to that conclusion reflects additional misapplications of established tie-in principles. For example, the court mechanically classified the aggregation of surgical and anesthesia services as a "two-product" package, each component of which patients should be free to obtain separately. In contrast to the automatic approach adopted below, this Court has made clear that the mere separability of combined products or services does not suffice for invocation of the tying doctrine. *Times Picayune Publishing Co.* v. *United States*, 345 U.S. 594, 613-614 (1953). Accordingly, the separability test employed by the court of appeals does not comply with this Court's instruction that the gravamen of the tie-in offense is "the forced purchase of a second *distinct* commodity * * * resulting in economic harm to competition in the 'tied' market." *Id.* at 614; emphasis added. See Gov't Pet. Br. 7-12.[11]

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[10] *Dos Santos* v. *Columbus-Cuneo-Cabrini Medical Center*, 684 F.2d 1346 (7th Cir. 1982); *Capili* v. *Shott*, 620 F.2d 438 (4th Cir. 1980); *Harron* v. *United Hospital Center, Inc.*, 522 F.2d 1133 (4th Cir. 1975), cert. denied, 424 U.S. 916 (1976); *Smith* v. *Northern Michigan Hospitals, Inc.*, 518 F. Supp. 644 (W.D. Mich. 1981), aff'd, No. 81-1513 (6th Cir. Mar. 25, 1983). See the recent advisory opinion by the Federal Trade Commission, appended to petitioner's brief at A-1 to A-10. See also *Robinson* v. *Magovern*, 521 F. Supp. 842 (W.D. Pa. 1981), aff'd mem., 688 F.2d 824 (3d Cir. 1982), cert. denied, No. 82-415 (Nov. 1, 1982).

[11] "Gov't Pet. Br." refers to the government's amicus curiae brief filed in support of the petition for a writ of certiorari.

Further, the court's geographic market definition and resulting finding of substantial market power in the market for surgical services ignored clearly supported findings of fact made by the district court. See Gov't Pet. Br. 12-14. This Court's decision in *Tampa Electric Co.* v. *Nashville Coal Co. supra*, 365 U.S. at 331, teaches that a court must identify the "relevant market of effective competition." See *Robinson* v. *Magovern*, 521 F. Supp. 842, 878 (W. D. Pa. 1981), aff'd mem., 688 F.2d 824 (3d Cir. 1982), cert. denied, No. 82-415 (Nov. 1, 1982). In this case, the court of appeals pared down the geographic market determined by the district court[12] and then, on the basis of this reduced area, concluded that the Hospital wielded sufficient power to warrant application of the per se standard. In our view, the Fifth Circuit was incorrect in redrawing the borders of the market, and consequently erred in assessing the Hospital's power in that market. Indeed, the court below acknowledged that under the "traditional method of economic power analysis" the respondent "has failed to prove an illegal tying arrangement" (Pet. App. 8a). Only by relying on its own assessment that patients "select the hospital closest to home" and prefer a "non-profit entity" (*id.* at 9a), did the court reject the traditional analysis and the district court's conclusions. The court's reliance on these factors was misplaced as a matter of law (see Gov't Pet. Br. 13-14).

Any one of these errors would suffice to justify reversal by this Court. But we believe that the fundamental error in the court of appeals' decision is its wooden characterization of the contract as a "tie-in" and the resulting condemnation of the arrangement as per se unlawful. The court of appeals' opinion is virtually a roadmap showing how the hypertechnical affixing of labels, without meaningful substantive analysis, can lead to results that distort the federal antitrust laws. Because antitrust legality should turn on a reasonable assessment of likely competitive effects, the fact that a practice could fit within a particular rubric—*e.g.*, "tie-in" or "exclusive dealing"—should not be determina-

[12] The court of appeals did not conclude that the district court's findings of fact on market definition were clearly erroneous; it therefore erred in substituting its judgment on these factual matters. Fed. R. Civ. P. 52(a); *Inwood Laboratories, Inc.* v. *Ives Laboratories, Inc.*, No. 80-2182 (June 1, 1982), slip op. 10-13; *Pullman-Standard* v. *Swint*, 456 U.S. 273, 290-292 (1982).

tive. See *Continental T.V., Inc.* v. *GTE Sylvania, Inc.*, 433 U.S. 36, 47 (1977); *Broadcast Music, Inc.* v. *CBS*, 441 U.S. 1, 9 (1979). In order to avoid similar errors in future cases, and to assist the court of appeals should the case be decided on narrower grounds and remanded, we urge this Court to articulate criteria that address the primary antitrust inquiry: whether a challenged practice is likely to harm competition.

II. THIS COURT SHOULD ARTICULATE EXPLICITLY THE FACTORS THAT ARE OFTEN IMPLICITLY USED TO CHARACTERIZE AND EVALUATE THE LEGALITY OF TIE-INS

A. Tie-ins Were Placed In The Category Of Per Se Offenses Because They Were Perceived To Be A Monopolization Device

This Court first placed "tying" arrangements in the category of conduct deemed illegal per se under the Sherman Act in *International Salt Co.* v. *United States*, 332 U.S. 392, 396 (1947). Tying arrangements were viewed as "serv[ing] hardly any purpose beyond the suppression of competition" (*Northern Pacific Ry.* v. *United States*, 356 U.S. 1, 6 (1958)); they were considered to be a coercive means by which a seller with economic power in one market (the tying product) could extend that power into another market (the tied product). *International Salt Co.* v. *United States*, *supra*, 332 U.S. at 396; *Standard Oil Co.* v. *United States*, 337 U.S. 293, 305-306 (1949); *Times-Picayune Publishing Co.* v. *United States*, 345 U.S. 594, 611 (1953). The per se rule against tie-ins, therefore, was based on the desire to prevent the expansion or extension of monopoly power from one market to another. *Times-Picayune*, *supra*, 345 U.S. at 611; *Fortner Enterprises, Inc.* v. *United States Steel Corp.*, 394 U.S. 495, 498-499 (1969) (*"Fortner I"*); *United States Steel Corp.* v. *Fortner Enterprises, Inc.*, 429 U.S. 610, 617-618 & n.8 (1977) (*"Fortner II"*).

The per se rule involving tie-ins has, from its inception, differed from other applications of that standard in one significant respect. Per se rules ordinarily preclude analysis of anticompetitive effects or consideration of defense "justifications." See *Broadcast Music, Inc.* v. *CBS*, *supra*, 441 U.S. at 17. Thus, in a price-fixing case a plaintiff need not

prove anticompetitive effect, nor may defendants justify their behavior because their conspiracy was ineffective or set prices that were in fact at a competitive level. In applying the tying doctrine, however, the courts have recognized that not every practice that could literally be characterized as a "tie-in" invariably justifies condemnation under the Sherman Act. Indeed, the tie-in rules laid down by this Court explicitly require an inquiry into facts peculiar to the products and markets at issue to determine whether one product is being tied to a separate product, whether the seller has sufficient economic power in the tying product market, and whether a "not insubstantial" amount of commerce in the tied market is involved. *Times-Picayune*, *supra*, 345 U.S. at 608-614; *Fortner I*, *supra*, 394 U.S. at 498-500. These rules thus make some attempt to assess the seller's power in the tying market and to assess foreclosure of competing producers in the tied market—factors more akin to the rule of reason analysis employed for other vertical restraints—before judging the arrangement to be per se illegal.[13] In addition to this three-part inquiry, moreover, some lower courts have accepted evidence of "business justifications" or "lack of anticompetitive effects" to avoid application of the per se rule to tie-ins that do not threaten competition. See, *e.g.*, *United States* v. *Jerrold Electronics Corp.*, 187 F. Supp. 545, 559-560 (E.D. Pa. 1960), aff'd per curiam, 365 U.S. 567 (1961);[14] *Coniglio* v.

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[13] If an alleged tie-in does not meet the "separate product," tying market power, and "not insubstantial" amount of commerce tests, then it is judged under the rule of reason. *Times-Picayune*, *supra*, 345 U.S. at 614.

[14] In *Jerrold Electronics* the district court found that, while the government had elsewhere established a two-product tie-in of community antenna equipment to engineering service contracts, and where the other prerequisites of "economic power" and effects on a "not insubstantial amount of interstate commerce" were met, the unique circumstances of the case nonetheless justified a refusal to condemn the tie-in. 187 F. Supp. at 555-556. The court found the tie-in to be reasonable, hence legal, because it was used "to foster the orderly growth of the industry on which the future of Jerrold depended." *Id.* at 557. This "business justification defense," as it has come to be called (see, *e.g.*, Baker, *The Supreme Court and the Per Se Tying Rule: Cutting the Gordian Knot*, 66 Va. L. Rev. 1235, 1249-1251(1980)), is something that per se rules normally do not permit. E. Singer, *Antitrust Economics and Legal Analysis* 109-110 (1981).

Highwood Services, Inc., 495 F.2d 1286 (2d Cir.), cert. denied, 419 U.S. 1022 (1974); cf. *Foremost Pro Color, Inc.* v. *Eastman Kodak Co.*, No. 80-5629 (9th Cir. Feb. 23, 1983).

In the following sections, we will examine the unusual application of the per se test as it has been implemented by the courts in cases alleging tie-ins.

B. The Better Reasoned Tie-in Decisions Have Permitted Some Extended Competitive Analysis Within The "Per Se" Framework

1. In this case, the Hospital's provision of surgical and anesthesia services as a single package can literally be characterized as a "tie-in." But the simple fact that a label can be applied to a practice does not necessarily determine its potential for anticompetitive effect and should not, therefore, be dispositive of its legality.[15] *Continental T.V. Inc.*, v. *GTE Sylvania, Inc.*, *supra*, 433 U.S. at 47; *Broadcast Music* v. *CBS*, *supra*, 441 U.S. at 9. As a consequence, some of the lower courts have recognized the potential procompetitive functions of tie-ins and have, accordingly, applied the per se rules laid down by this Court in a manner that takes into account the competitive effects and business justifications for the conduct at issue.

2. Some courts have used the one-product/two-product test to justify an inquiry into the business considerations relevant to a challenged tying practice, and have avoided classifying a packaged sale as illegal absent a realistic threat of anticompetitive effects. See Baker, *The Supreme Court and the Per Se Tying Rule: Cutting the Gordian Knot*, 66 Va. L. Rev. 1235, 1315 (1980). For example, in *United States* v. *Jerrold Electronics Corp.*, *supra*, 187 F. Supp. at 559-560, the court accepted "a sound business reason" (*i.e.*, the inability to launch and develop an experi-

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[15] In this case the tie-in was the inevitable result of the Hospital's exclusive dealing contract with Roux. If such an exclusive contract were legal under the rule of reason approach that is generally applied to nonprice vertical restraints, then as a matter of logic the tie-in automatically following from that arrangement should be legal. Whether the practice is viewed as an exclusive dealing arrangement or a tie-in, therefore, the antitrust analysis should follow the same course.

mental business using sensitive and unstable equipment unless service was sold in a package with the equipment) as a legal justification for the sale of a package of various items of equipment designed for community antenna systems.[16] Similarly, in *Hirsh* v. *Martindale-Hubbell, Inc.*, 674 F.2d 1343, 1347-1348 (9th Cir. 1982), cert. denied, No. 82-570 (Nov. 1, 1982), the court observed that it must consider "whether the aggregation serves to facilitate competition by promoting product quality or whether it, in fact, amounts to no more than a naked effort to impede competition on the merits" and that "where * * * the aggregate sale of ostensibly separate items serves to improve the quality of the product offered by the seller * * * no tying arrangement is present."

Unless a court is as discerning as the *Jerrold* and *Hirsh* courts were to go beneath the surface of the literal tie-in rules to examine competitive realities, it may feel obliged to find a practice per se illegal even though the procompetitive benefits may outweigh any ancillary anticompetitive effects. This more mechanistic approach is demonstrated by the decision below. The court of appeals found it "clear," without any analysis, "that we are dealing with two distinct services which a buyer should be able to obtain separately" (Pet. App. 5a-6a). This cursory consideration, amounting to a "separability" test, led the court to ignore both the close functional relationship between the "tied" services, and the vertical integration achieved by the challenged contract.[17]

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[16] Accord, *Dehydrating Process Co.* v. *A.O. Smith Corp.*, 292 F.2d 653, 655-656 (1st Cir.), cert. denied, 368 U.S. 931 (1961) ("sound business interests of the seller" warranted treatment of components as "inseparable"); *Foster* v. *Maryland State Savings & Loan Ass'n*, 590 F.2d 928, 932 (D.C. Cir. 1978), cert. denied, 439 U.S. 1071 (1979) ("Incidental services purchased by the seller (lender) for legitimate business reasons cannot be viewed as a separate (or tied) product, merely because the buyer is charged for them"); cf. *Siegel* v. *Chicken Delight, Inc.*, 448 F.2d 43, 48 (9th Cir. 1971), cert. denied, 405 U.S. 955 (1972) (package may be single product where the amalgamation results in cost savings apart from reduction in sales expenses and the like, or where the items are normally sold or used in fixed proportions).

[17] Many items can be broken down into components that conceivably could be offered for sale separately. For example, a pair of shoes is lit-

By contrast, many lower courts have looked beyond the separability of products sold as a package in determining whether to treat an aggregation as an illegal "tie"; they have instead looked to the seller's reasons for coupling the products and the policies underlying the tying rule as guides to characterization.[18] Unlike the oversimplified ap-

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erally a "tie" of one right and one left shoe and, going further, of shoes and laces, heels and soles. It is, of course, preposterous to suggest that the sale of shoes in pairs is an illegal tie-in; but the illustration is instructive in two respects. First, it highlights the pitfalls of a hypertechnical approach to the one product/two product issue. And, if we analyze the reasons why pairs of shoes are not illegally tied products we can discern rules of more general application. A shoe has no commercial utility without its mate; consumers expect to purchase the pair as a unit; there are not separate markets for right and left shoes, negating the possibility that power in one market could be "leveraged" into the other; competitors are easily able to duplicate the "package"; and finally, there are efficiencies that can be realized in manufacture and distribution. The same factors are present in this case. Yet the court of appeals' elevation of formal labels over substance left no place for consideration of the functional and economic justifications for the packaged sale of surgical and anesthetic services.

Proper product definition is "not bounded by the minimum product that could be or typically is sold, but rather bounded at the point where the amalgamation appears to have relatively little economic justification." Turner, *The Validity of Tying Arrangements Under the Antitrust Laws*, 72 Harv. L. Rev. 50, 71-72 (1958); R. Bork, *The Antitrust Paradox*, 371, 378-379 (1978); L. Sullivan, *Handbook of The Law of Antitrust* 455 (1977). "The definition of what constitutes a single product in a tying arrangement * * * may have to change with its economic environment." E. Singer, *supra*, at 114. Authors Dolan & Ralston, *Hospital Admitting Privileges and the Sherman Act*, 18 Hous. L. Rev. 707 (1981), suggest that factors relevant to a proper product definition of hospital services include: customary practices in the industry, the common understanding of people about such commodities, technological realities, and other economic efficiencies. *Id.* at 757. The authors also suggest that in specialties like anesthesiology, "custom requires the purchase of those services from the hospital" and "it could be reasoned that no tying agreement exists because of the close identity of the services and the hospital." *Id.* at 758.

[18] See, *e.g.*, *Krehl* v. *Baskin-Robbins Ice Cream Co.*, 664 F.2d 1348, 1354 (9th Cir. 1982); *Principe* v. *McDonald's Corp.*, 631 F.2d 303 (4th Cir. 1980), cert. denied, 451 U.S. 970 (1981); *Dehydrating Process Co.* v. *A.O. Smith Corp.*, *supra*; *United States* v. *Jerrold Electronics Corp.*, *supra*.

proach adopted by the Fifth Circuit, the better reasoned opinions have "long recognized that the rules governing tying arrangements are designed to strike solely at practices employed to impede competition on the merits." *Hirsh* v. *Martindale-Hubbell, Inc., supra*, 674 F.2d at 1348. As *Hirsh* and similar cases illustrate, the conclusion that an illegal tying arrangement exists cannot properly be reached without consideration of the purposes of the tying rule and the competitive function of the challenged aggregation of products. Because the Hospital's anesthesia contract combines functionally related services in an efficient form of vertical integration, it does not create a "forced purchase of a * * * distinct commodity" and may not cause "economic harm to competition in the 'tied' market." It therefore should not be characterized as the illegal sale of two distinct services. *Times-Picayune, supra*, 345 U.S. at 614. Nevertheless, the court of appeals failed to consider possible justifications for the bundling of anesthesia services with other hospital products and services, even while it acknowledged that the exclusive contract resulted in significant cost savings to the Hospital.[19]

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[19] The court of appeals erred in holding that such cost savings brought about an anticompetitive result merely by increasing the Hospital's profits. Pet. App. 11a-12a. Arrangements that increase efficiency and lower costs enhance welfare, even if they also increase a firm's profits. It is, of course, the profit incentive that motivates firms to innovate and to reduce costs.

The court was also incorrect in implying that anesthesiologists require special protection from nurse-anesthetists, their "paraprofessional counterpart[s]." Pet. App. 11a. To the contrary, the antitrust laws were promulgated to promote, not frustrate, the entry of competitive alternatives. The antitrust laws should not be transformed into a tool that allows competitors to prevent competition by competent, state-licensed, non-physician health care providers; their purpose, rather, is to assure that where state-authorized alternatives are available consumers have the option to use them.

The court's failure adequately to consider cost reductions and other competitive justifications was exacerbated by its invocation of the "less restrictive" alternative standard (Pet. App. 12a-13a). While the clear availability of such alternatives is a relevant factor in determining the existence of either anticompetitive intent or effect (see *White Motor Co.* v. *United States*, 372 U.S. 253, 270-272 (1963) (Brennan, J., concurring), it does not in itself prove that the means selected were ei-

Sellers throughout our economy offer aggregations of parts, products, and services that can be sold separately, but that sometimes may be supplied more efficiently and conveniently when packaged together. It is important that antitrust analysis distinguish aggregations that promote consumer welfare and competition from those that injure competition and coerce consumers. Pet. App. 5a-6a. Consequently, we believe that this Court should go beyond its tacit acceptance of the more sophisticated decisions that analyze the economics of a package sale before classifying it as a one- or two-product sale (see *Jerrold Electronics*, *supra*, 365 U.S. at 567),[20] and should explicitly require such an analysis in appropriate cases.[21]

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ther unreasonable or anticompetitive. The court of appeals' use of the rule would make firms

> guarantors that the imaginations of lawyers could not conjure up some method of achieving the business purpose in question that would result in a somewhat lesser restriction of trade. And courts would be placed in the position of second-guessing business judgments as to what arrangements would or would not provide 'adequate' protection for legitimate commercial interests.

American Motor Inns, Inc. v. *Holiday Inns, Inc.*, 521 F.2d 1230, 1249-1250 (3d Cir. 1975).

[20] This Court discussed the relevant considerations generally in *Times-Picayune Publishing Co.* v. *United States*, *supra*. There, the Court looked beyond mere separability, to the nature and function of the allegedly tied products and the realities of the market. 345 U.S. at 613. It then compared the challenged practice with the "common core of the adjudicated unlawful tying [cases]"—"the forced purchase of a second distinct commodity * * * resulting in economic harm to competition in the "tied' market." *Id.* at 614. Finding that "neither the rationale nor the doctrines evolved by the 'tying' cases" were involved, the Court refused to dispose of the case under the tying rule; it held instead that the challenged practice must be "tested under the Sherman Act's general prohibition on unreasonable restraints of trade." *Ibid.*

[21] Under the tie-in rules presently articulated, the one-product/two-product issue is the first one considered by the courts. Under criteria that focus on anticompetitive potential rather than on the form of the challenged conduct, however, one would not need to examine the separate product issue unless analysis indicated that the defendant possessed sufficient market power to enable a court to conclude that the tie-in had significant anticompetitive potential. In that situation, the defendant would have the burden of proving as an affirmative defense

3. The second pre-condition of a per se illegal "tie-in"—that the seller have significant economic power in the market for the tying product—has also been used by discerning courts to avoid automatic condemnation of sales of bundled products whose purpose and effect is unlikely to be anticompetitive. See *Fortner II, supra; Warner Management Consultants* v. *Data General Corp.*, 545 F. Supp. 956, 965-966 (N.D. Ill. 1982); *In re Data General Corp. Antitrust Litigation*, 529 F. Supp. 801, 806-821 (N.D. Cal. 1981); *JBL Enterprises, Inc.* v. *Jhirmack Enterprises, Inc.*, 509 F. Supp. 357, 377-378 (N.D. Cal. 1981); *Refrigeration Engineering Corp.* v. *Frick Co.*, 370 F. Supp. 702, 711-712 (W.D. Tex. 1974). Yet, the "economic power" test, as enunciated in some of this Court's decisions, may also lead to erroneous predictions of a tie-in's competitive effects. While on its face the "economic power" test may "suggest [] a discussion of the available economic evidence in what might appear to be a rule of reason approach" (see E. Singer, *Antitrust Economics and Legal Analysis* 109-110 (1981)), a number of this Court's earlier tie-in decisions indicated that the usual analytical means for ascertaining the existence of significant market power could be eschewed. Thus, under *United States* v. *Loew's, Inc.*, 371 U.S. 38 (1962), it did not appear necessary to determine the relevant geographic market share with any precision because sufficient power in the tying market could be inferred from the unique nature of the tying product, *e.g.*, a patent or a copyright.[22] *Id.* at 45-46, 48-49. Yet, a patented or

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that a combined sale afforded sufficient benefits to outweigh the anticompetitive potential.

[22] In *Standard Oil Co.* v. *United States*, 337 U.S. 293 (1949), the Court noted that in *International Salt* "[i]t was not established that equivalent machines were unobtainable, it was not indicated what proportion of the business of supplying such machines was controlled by defendant * * *." 337 U.S. at 305-306. The presumption of market control was based on the assumption that "only [the seller's] control of the supply of the tying device, whether conferred by patent monopoly or otherwise obtained, could induce a buyer to enter [a tying contract]." *Ibid.* Some courts of appeals have extended the *Loews'* "uniqueness" rationale to trademarks and franchises, finding not only that the trademark is a separate "product" from the product that the

copyrighted article is not necessarily a market unto itself; in many cases such articles have close substitutes that preclude the exercise of any significant degree of market power by the holder of the patent or copyright. As a result, it should not be presumed that a patent or copyright confers market power. *Walker Process Equipment, Inc.* v. *Food Machinery & Chemical Corp.*, 382 U.S. 172, 177-178 (1965); E. Singer, *supra*, at 112. In other tie-in decisions, the Court has said that sufficient economic power could be presumed from the existence of the tie itself. *Northern Pacific Ry.* v. *United States*, *supra*, 356 U.S. at 7-8. Yet, further analysis would suggest that the reason a buyer accepts a tie-in is just as likely to be buyer preference as seller coercion, see *Fortner II*, *supra*, 429 U.S. at 621-622, and thus the existence of the tie-in itself has no probative value in determining the existence of market power.

In *Fortner II* the Court seems to have retreated from the language of *Northern Pacific* and *Loew's* " 'which could be read to make actual market power irrelevant' " (*Fortner II*, *supra*, 429 U.S. at 620 & n.13), and reaffirmed the central importance of market power to the finding of an illegal tying arrangement. However, this apparently has eluded many courts that continue to seek guidance from pre-*Fortner II* precedent. See *Ware* v. *Trailer Mart, Inc.*, 623 F.2d 1150, 1154 (6th Cir. 1980); *Moore* v. *Jas. H. Matthews Co.*, 550 F.2d 1207, 1215 (9th Cir. 1977); *In re Data General Corp. Antitrust Litigation*, 490 F. Supp. 1089, 1112 (N.D. Cal. 1980). Even those courts that follow *Fortner II*, moreover, may be led astray. For instance, the test of "whether the seller has some advantage not shared by his competitors in the market for the tying product" (*Fortner II*, *supra*, 429 U.S. at 620) might appear to encompass a finding that a product with a favorably regarded brand name, or the corner grocery store, or the nearby hos-

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trademark represents (*Siegel* v. *Chicken Delight*, *supra*, 448 F.2d at 48 & n.2), but also that the uniqueness of the trademark is sufficient by itself to support a finding of economic power in the tying product market. *Id.* at 50; *Warriner Hermetics, Inc.* v. *Copeland Refrigeration Corp.*, 463 F.2d 1002, 1015 (5th Cir.), cert. denied, 409 U.S. 1066 (1972).

pital, has market power simply by reason of its reputation or close proximity to a core of neighborhood users. Indeed, in this case the court of appeals, purporting to rely on *Fortner II* for its economic power analysis (Pet. App. 8a), found that the Hospital possessed the significant market power necessary for a per se determination despite the fact that there is nothing in its opinion that indicates the Hospital possessed either market dominance or any distinct advantage over its competitors for offering a unique or differentiated product. See *Fortner II*, *supra*, 429 U.S. at 620-621. The court of appeals' finding of "sufficient market power" based solely on the Hospital's 30% share of patients living on the East Bank of Jefferson Parish (Pet. App. 10a), without examination of the proper standards for defining a relevant market, defeats any rational aim of using "economic power" to gauge the likelihood of anticompetitive effects. The district court's finding that the relevant geographic market included the larger group of 20 hospitals in the metropolitan New Orleans area—and that 70 % of patients from the East Bank of Jefferson Parish go to hospitals other than petitioners'—is reasonable on its face and should not have been rejected by the court of appeals absent findings that disclose clear error by the district court.[23]

4. While some courts have been willing to analyze the one/two product issue and the tying product market power issue by focusing on business efficiency and market power, none has analyzed the third element of the per se test—the impact on the tied product market—in terms of actual effects on market structure, behavior, or performance. Although the illegality of tie-ins is said to rest on their potential to extend market power into the tied product market (*International Salt*, *supra*, 332 U.S. at 396; *Times-Picayune*, *supra*, 345 U.S. at 611), current tie-in rules focus not on competitive effect in the tied market, but solely on the dollar volume of commerce affected by the arrangement. *Fortner I*, *supra*, 394 U.S. at 501; *Northern Pacific*

[23] See pp. 8-9, *supra*. In *Times-Picayune*, *supra*, 345 U.S. at 611, this Court instructed that "the whole and not part of a relevant market must be assigned controlling weight" when testing the strength of a firm's tying "lever."

Ry., *supra*, 356 U.S. at 9. Yet this test tells us nothing about whether the extension of market power or foreclosure of competitors is of a magnitude sufficient to affect market structure or pricing pressures. It does not attempt to assess the seller's ability to affect the tied market, or the likely result of the tie-in on market shares, price, or output. For other forms of vertical restraint, however, which are analyzed under the rule of reason, the market inquiry squarely addresses likely competitive effects as they may be predicted from changes in market power and structure. *Tampa Electric Co.* v. *Nashville Coal Co.*, 365 U.S. 320, 329 (1961). This disparity in treatment between tie-ins and all other forms of nonprice vertical arrangements elevates form over substance. See *Continental T.V., Inc.* v. *GTE Sylvania, Inc.*, *supra*, 433 U.S. at 47. Given the ambiguity of the characterization of the conduct here as "tying" or "exclusive dealing," it is particularly important that formal labels not be the sole determinant of legality. See *Broadcast Music, Inc.* v. *CBS*, *supra*, 441 U.S. at 9. Since the anticompetitive potential of tie-ins and exclusive dealing contracts is basically identical, both arrangements should be judged by the same criteria. See Baker, *supra*, 66 Va. L. Rev. at 1306.[24]

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[24] In this case the court of appeals found the contract with Roux to be anticompetitive because it "prevents anesthesiologists from entering that part of the anesthesia services market which the hospital controls", and it "eliminates the surgeon's or patient's choice of anesthesiologist at this hospital." Pet. App. 12a. But this degree of foreclosure and limitation on consumer choice is inherent in any contract for the sale of goods or services. Without an assessment of the market, and the effects of foreclosure on competition, the court's findings are meaningless as a test for judging the reasonableness of the restraint. See *Chicago Board of Trade* v. *United States*, 246 U.S. 231, 238 (1918).

III. Economic and Legal Analysis Indicates That There Is Only A Narrow Range Of Conditions Under Which Tie-Ins Are Likely To Produce Anticompetitive Effects

As we have just discussed, the history of the tying doctrine in the federal courts reveals at least a tacit recognition that the doctrine does not fit comfortably within the category of offenses branded illegal per se. While this Court has labeled many tie-ins per se offenses, it—and the lower courts—have usually looked to economic factors relevant to a particular sales arrangement before deciding whether to place it in the per se category. The label applied to such an analytical approach—"per se", "modified per se," or "rule of reason"—is ultimately unimportant so long as the analysis aimed at identifying anticompetitive conduct is sound. The discussion above indicates that, while some courts have applied the existing per se rules to take into account competitive effects and avoid striking down conduct that is not anticompetitive, courts that have been less discerning or have felt more constrained by the per se label have not undertaken sufficient competitive analysis.[25]

Although the existing rules implicitly acknowledge the need to consider cost justifications for offering a product "package" (the "one-product/two-product" test), and the need for finding a degree of market power in the tying product sufficient to enable a seller to expand that power through a tied sale (the "economic power" test), the rules should be more explicit to demand employment of these two tests as a prerequisite to a finding of illegality in every tie-in case. Moreover, the existing rules, which now require

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[25] *E.g.*, *Earley Ford Tractor, Inc.* v. *Hesston Corp.*, 1983-1 Trade Cas. ¶ 65,232 (W.D. Mo. 1982) (once literal criteria for identifying a tie-in are met, no other justification is appropriate); *Rosebrough Monument Co.* v. *Memorial Park Cemetery*, 666 F.2d 1130, 1143 (8th Cir. 1981) (a cemetery plot is "unique" for market power analysis; volume of commerce is sufficient if it meets the tests established under "interstate commerce" criteria); *Siegel* v. *Chicken Delight, Inc.*, *supra*, 448 F.2d at 50; *Photovest Corp.* v. *Fotomat Corp.*, 606 F.2d 704, 722 (7th Cir. 1979), cert. denied, 445 U.S. 917 (1980) (franchise can be a separate tying product).

only that a "not insubstantial" amount of commerce be affected in the market for the tied product, should be modified to require instead a true competitive analysis of the effects of the tying arrangement on the tied product market. Such a competitive analysis turns not on the quantitative amount of commerce affected, but rather on the relationship of the tying arrangement to the possibility that the defendant might exercise market power in the tied product market. With these modifications, the rules governing the legality of tying arrangements would be consistent with the approach employed in the more rigorously analytical cases; they would also, as we now discuss, make unlawful those tying arrangements with anticompetitive effects about which this Court was properly concerned in its earlier tie-in cases, without impeding those tying arrangements that are procompetitive or are competitively neutral.

1. Since *International Salt* and its immediate progeny, legal scholars and economists have come to recognize that existing precedent both underestimates the extent to which alleged tie-ins may be procompetitive or competitively neutral, and overestimates the frequency with which they pose potential anticompetitive problems.

Profit-seeking firms have strong incentives to find the most efficient ways to distribute their goods and services to consumers, so as to maximize their sales and hence their profits. Efficient distribution benefits consumers as well, providing them with the goods and services they want at the lowest cost. A failure on the part of a supplier to distribute its goods and services in the most efficient way opens the possibility that it will be undercut by its more efficient competitors, who will be able to price their products below the higher prices resulting from the supplier's distribution inefficiencies. As a result, the interests of a supplier and of consumers in achieving an efficient distribution system are usually coincident.

Accordingly, the strong presumption should be that a supplier will choose that method of distribution that yields the most attractive package to consumers in terms of price, product mix and quality. In particular, where a supplier chooses to offer physically separable products only in a

single package, the choice ordinarily will reflect the supplier's judgment that this method of distribution is the most likely to satisfy consumer preferences at the lowest price and so enhance the supplier's ability to compete in the marketplace.

Besides cost efficiencies in distribution, a number of other beneficial uses of tie-ins have been observed (*Fortner I*, *supra*, 394 U.S. at 514 n.9 (White, J., dissenting)):

> They may facilitate new entry into fields where established sellers have wedded their customers to them by ties of habit and custom. *Brown Shoe Co.* v. *United States*, 370 U.S. 294, 330 (1962); Note, Newcomer Defenses: Reasonable Use of Tie-ins, Franchises, Territorials, and Exclusives, 18 Stan. L. Rev. 457 (1966). They may permit clandestine price cutting in products which otherwise would have no price competition at all because of fear of retaliation from the few other producers in the market* * *. And, if the tied and tying products are functionally related, they may reduce costs through economies of joint production and distribution.

See also E. Singer, *supra*, at 106. Another recognized justification for tying is to protect the seller's goodwill by assuring that the tying product is used with essential complements that do not impair the product's quality or performance. *United States* v. *Jerrold Electronics Corp.*, *supra*, 187 F. Supp. at 559. See E. Singer, *supra*, at 113-114; R. Bork, *supra*, at 379-380; Bowman, *Tying Arrangements and the Leverage Problem*, 67 Yale L.J. 19, 27 (1957); Markovits, *Tie-ins, Reciprocity, and the Leverage Theory*, 76 Yale L.J. 1397, 1459 (1967); see also *Pick Mfg. Co.* v. *General Motors Corp.*, 80 F.2d 641, 643 (7th Cir. 1935), aff'd per curiam, 299 U.S. 3 (1936).

2. However, as this Court has recognized, in some instances the supplier may have an incentive to use an inefficient tying arrangement (*i.e.*, one that does not minimize the costs of supplying the products, contrary to the interests of consumers) in order to achieve an anticompetitive effect. The courts and commentators have identified two principal types of anticompetitive harm that might arise from a tying arrangement: (1) where the defendant uses its

market power in the tying product in order to foreclose other sellers and make it more difficult for new firms to enter either the tying product or tied product markets; and (2) where the defendant uses its market power in the tying product in order to extract supracompetitive profits from consumers in their purchase of the tied product (the "leverage" theory).[26]

a. Under the foreclosure theory, the supplier uses a tying arrangement to raise barriers that increase the manufacturing or distribution costs of its rivals in the market for one of the products in the tying package and thereby enhances the supplier's ability to obtain supracompetitive profits. See *Hirsch* v. *Martindale-Hubbell, Inc.*, *supra*, 674 F.2d at 1349; P. Areeda, *Antitrust Analysis* 569-570 (2d ed. 1974); L. Sullivan, *Handbook of the Law of Antitrust* 447-448 (1977). Under the appropriate conditions, foreclosure through a tying arrangement may increase the relative costs of the supplier's competitors by forcing them to produce both the tying and the tied products.[27]

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[26] Other potential uses for a tying arrangement, which may or may not be anticompetitive depending on the circumstances, are where it is used as a counting device for metering demand (see note 30, *infra*) and where the defendant uses the tying arrangement to evade price controls in a regulated tying product market through clandestine transfer of the profit to the tied product. See generally *Fortner I*, *supra*, 394 U.S. at 512-514 (White, J., dissenting); quoted in *Foremost Pro Color, Inc.* v. *Eastman Kodak Co.*, *supra*, slip op. 875 n.3; E. Singer, *supra*, at 105-109.

[27] This may occur where the tying and tied products in the package are complements (*i.e.*, products that are used in combination), as in the case of central processing units ("CPU's") and peripheral equipment (punch card readers, storage discs, printers, etc.). A monopolist CPU manufacturer might tie peripheral equipment to the sale of the CPU and, as a result, inhibit the entry of independent manufacturers of peripheral equipment because of a lack of potential customers. Conversely, entry into the CPU market may also be impeded, for in the absence of an available supply of peripheral equipment from independent producers the new CPU entrant would have to produce peripherals as well.

If the degree of foreclosure in the market for the tied product is small, the supplier's competitors simply can turn to other, non-foreclosed customers with little or no negative effect on competition. To be anticompetitive, the supplier must have power in the market for the tying product to coerce the purchase of the tied product by those who would otherwise purchase it elsewhere; absent market power, consumers would be free to look to the supplier's competitors as an alternative source of supply and anticompetitive foreclosure could not occur.[28]

Moreover, if the supplier does not also have market power in the tied product, whatever foreclosure might result from a tying arrangement cannot have an anticompetitive effect. Only if the tying arrangement results in the elimination of enough existing rivals in the tied product market to give the supplier power in that market will the arrangement itself be anticompetitive. L. Sullivan, *supra*, at 445-446. So long as the remaining independent competitors in the relevant tied product market can produce output for sale at the competitive price, the tying arrangement itself cannot create or enhance the power of the tying firm to obtain supracompetitive profits through foreclosure of other firms.[29]

b. The "leverage" theory can be seen as the consumer counterpart to the foreclosure theory. The anticompetitive harm under the leverage theory flows from the use of a tying arrangement to extract supracompetitive profits from consumers that otherwise would not be available to the ty-

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[28] This explains why true market power in the market for the tying product—and not merely the "economic power" lower courts were willing to find on the basis of the "uniqueness" of the tying product—is necessary for an anticompetitive effect to occur under the leverage theory. See pp. 17-18, *supra*.

[29] Even if the tying arrangement can be shown to reduce the number of the supplier's competitors, this reduction does not necessarily imply less effective competition for consumer dollars. Indeed, where a tying arrangement increases the efficiency of a supplier's distribution system, it may well result in the elimination of those competitors who are not as efficient. The antitrust laws are designed "for the protection of competition, not competitors." *Brunswick Corp.* v. *Pueblo Bowl-O-Mat, Inc.*, 429 U.S. 477, 488 (1977).

ing firm. These profits arise because entry into one or both product markets has been made more difficult—and thus consumers have been deprived of the extra output and the lower prices that the foreclosed entrants would have provided. Thus, again, market power is clearly needed in the tying good; and contrary to the assumption of many lower courts, market power in the tied good is needed as well. In the absence of market power in both markets, entry will not be inhibited, and the tying arrangement will not allow the extraction of supracompetitive profits from consumers.[30]

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[30] While the terms "leverage" and "extension of monopoly" sometimes refer to enhancement of the supplier's market power, as described above, these terms have more often been used to describe an alternative hypothesis on which the condemnation of tie-ins has been based, *i.e.*, that, through tying, a firm can use its market power in the tying product market, to create new market power (typically in the tied product market) and thereby increase overall profitability. The deficiency in this version of the leverage argument can be grasped by asking why a firm with monopoly power over a single product does not extend its monopoly to a multitude of other products by insisting that those products also be purchased from it as a condition for purchasing the monopolized product. The answer is that there is some limit to the amount each consumer would pay for the tying product; and, if the seller has extracted this maximum amount from each consumer, it cannot "force" consumers to purchase a tied product that would ordinarily be obtained elsewhere. It can "force" the purchase of the tied product only to the extent it lowers the price of the tying product. See P. Areeda, *supra*, at 569; L. Sullivan, *supra*, at 446-447. As a result, where they have anticompetitive effects, "tie-ins" are usually a device for exploiting pre-existing market power in the tying market, rather than a means of generating new market power in either the tied or tying market. Indeed, many observers believe that "[m]onopoly in the tied product is both rare and not often threatened by most actual tying arrangements." P. Areeda, *supra*, at 70; accord, Markovits, *supra*, *Reciprocity, and the Leverage Theory*, 76 Yale L.J. at 1397-1398; Burstein, *A Theory of Full-Line Forcing*, 55 Nw.U.L. Rev. 62-63, 93 (1960).

It is possible, of course, that the seller cannot extract the maximum revenue from each consumer solely by manipulating the price of the tying product. Consumers might differ in the strength of their preferences for the product, but the seller might be unable to charge them different prices (because he lacked information about individual consumer demands, because he could not prevent arbitrage among con-

It should not be surprising that both the leverage theory and the foreclosure theory posit the same necessary preconditions for anticompetitive harm: market power in both the markets for the tying and tied products. The leverage theory looks at competition through the eyes of the consumer, while the foreclosure theory looks at competition through the eyes of the producer. But since both theories ultimately look at the same thing—competition—the necessary conditions for an adverse effect are identical.

3. In view of this economic analysis and the Court's implicit acceptance of competitive impact as a factor in analyzing business conduct, we believe it would now be appropriate for this Court to offer clearer guidance by requiring explicitly a complete, but focused, examination of the factors that are most significant in predicting whether, in particular cases, practices that may be viewed as tie-ins might serve anticompetitive purposes. These factors include, first, whether the defendant has substantial market

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sumers, or because prices or price differences are regulated by law). If so, a tie-in of a complementary product, the demand for which varied in proportion with the frequency or intensity of use of the tying product (*e.g.*, a stapling machine and staples), could be used both to meter the intensity of demand for the tying product and to extract revenue reflecting this intensity by raising the price of the tied, metering product. Cf. *IBM Corp.* v. *United States*, 298 U.S. 131 (1936); *International Salt Co.* v. *United States*, 332 U.S. 392 (1947); *Henry* v. *A.B. Dick Co.*, 224 U.S. 1 (1912). See P. Areeda, *supra*, at 570; Bowman, *supra*, 67 Yale L.J. at 23. Where tie-ins are used for such metering purposes, the economic effects are ambiguous depending on the specific circumstances. The use of a tie-in to meter demand and collect revenue clearly can increase the output of the tying product. See O. Williamson, *Markets and Hierarchies: Analysis and Antitrust Implications* 11-13 (1975); R. Bork, *supra*, at 375-376. The use of tie-ins for metering can also, of course, lead to a decrease in output, but we believe that, more often than not, such tie-ins will tend to increase output and will thereby tend to be procompetitive. Tie-ins employed for metering purposes need not drive out independent suppliers in the tied market. Sellers would be perfectly willing to purchase the tied products from the most efficient independent suppliers, mark up their price, and resell them to buyers of the tying product. The ability to charge the higher prices for the tied product derives, not from having obtained market power over the tied product, but from market power possessed over the tying product.

power in the relevant product and geographic markets for the tying product and, second, whether there is a reasonable possibility that the defendant will obtain substantial market power in the relevant market for the tied product after the tie-in. Where one or both of these factors is absent, the danger of anticompetitive effects is absent and further inquiry is unnecessary. Where both factors are present, there may be significant anticompetitive potential and the defendant should be required to demonstrate justifications for the packaged sale sufficient to outweigh its potential adverse effects.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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MAY 1983

No. 82-1031-CFX
Status: GRANTED

Title: Jefferson Parish Hospital District No. 2, et al., Petitioners
v.
Edwin G. Hyde

Docketed:
December 17, 1982

Court: United States Court of Appeals for the Fifth Circuit

Counsel for petitioner: Easterbrook, Frank H.

Counsel for respondent: Landis, John M., Lansdale, John Jr.

Entry	Date	Note	Proceedings and Orders
1	Dec 17 1982	G	Petition for writ of certiorari filed.
3	Dec 27 1982		Order extending time to file response to petition until February 15, 1983.
4	Jan 18 1983	G	Motion of Louisiana Hospital Association for leave to file a brief as amicus curiae filed.
5	Feb 14 1983		Brief of respondent Hyde, Edwin G. in opposition filed.
6	Feb 15 1983		Brief amicus curiae of United States filed.
7	Feb 16 1983		DISTRIBUTED. March 4, 1983
8	Feb 17 1983	G	Motion of American Hospital Association for leave to file a brief as amicus curiae filed.
9	Feb 28 1983		DISTRIBUTED. March 4, 1983
11	Feb 28 1983		(DIST. 3/4/83. (Motion of Am. Hosp. Assn. for leave to file a brief as amicus curiae)
12	Feb 28 1983		(Motion of Am. Hosp. Assn. for leave to file a brief as amicus curiae.
13	Mar 7 1983		Motion of Louisiana Hospital Association for leave to file a brief as amicus curiae GRANTED.
14	Mar 7 1983		Motion of American Hospital Association for leave to file a brief as amicus curiae GRANTED.
17	Mar 7 1983		Petition GRANTED.
			**********
21	Apr 12 1983		Order extending time to file brief of petitioner on the merits until May 13, 1983.
22	May 9 1983		Brief amicus curiae of Louisiana Hospital Assn. filed.
23	May 12 1983		Brief amicus curiae of College of American Pathologists filed.
24	May 13 1983		Brief of petitioner Jefferson Parish Hosp., et al. filed.
25	May 16 1983		Brief amicus curiae of American Hospital Assn. filed.
26	May 13 1983		Brief amicus curiae of Natl. Assn. of Private Psychiatric Hospitals filed.
27	May 16 1983		Brief amicus curiae of American Assn. of Nurse Anesthetists filed.
28	May 14 1983		Brief amicus curiae of United States filed.
29	May 13 1983		Joint appendix filed.
31	May 20 1983		Order extending time to file brief of respondent on the merits until July 7, 1983.
32	May 23 1983		Record filed.
33	May 23 1983		Certified original transcript of record 8 C.A. proceedings, 6 volumes received.
34	May 20 1983	G	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided

No. 82-1030-CFX

Entry	Date	Note	Proceedings and Orders
			argument filed.
35	Jun 13 1983		Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
36	Jun 23 1983		Brief amicus curiae of Assn. of Amer. Physicians & Surgeons, Inc. filed.
37	Jul 8 1983		Brief amicus curiae of Louisiana State Medical Society filed.
38	Jul 7 1983		Brief of respondent Hyde, Edwin G. filed.
39	Jul 8 1983		Brief amicus curiae of American Society of Anesthesiologists filed.
40	Aug 2 1983		CIRCULATED.
41	Aug 30 1983	D	Motion of American Society of Anesthesiologists, Inc. for leave to file out-of-time motion for leave to participate in oral argument as amicus curiae and for divided argument filed.
42	Sep 21 1983		SET FOR ARGUMENT. Wednesday, November 2, 1983. (3rd case) (1 hour)
43	Oct 3 1983		Motion of American Society of Anesthesiologists, Inc. for leave to file out-of-time motion for leave to participate in oral argument as amicus curiae and for divided argument DENIED.
44	Oct 25 1983	X	Reply brief of petitioners Jefferson Parish Hosp., et al. filed.
45	Nov 2 1983		ARGUED.